

South Dakota State Employee Health Plan

SUMMARY PLAN DESCRIPTION DOCUMENT

**FY17
Health Plan**

The description in this Summary Plan Description Document does not imply that you have enrolled in these Plans. Your enrollment in any or all of these benefits is determined by records maintained by the Bureau of Human Resources. As Plan Administrator, the Bureau of Human Resources has final authority to make determinations on eligibility, enrollment and issues not specifically addressed in Plan provisions, ambiguously written provisions, or verbal representations that appear to conflict with any section of this official Summary Plan Description Document. The information contained in this Summary Plan Description Document and its interpretation by the Plan Administrator (the Bureau of Human Resources) or the Plan Administrator's designee supersedes all verbal representations of the Plan provisions and will govern in all cases.

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MASTER SCHEDULE

South Dakota State Employee Health Plan (Administered by the Commissioner of the Bureau of Human Resources of the State of South Dakota)

Effective Date:	July 1, 2016
Eligible Class:	A permanent full-time employee, permanent part-time employee, a retiree under 65 years of age, or an employee employed by a participating unit who has worked an average of 30 hours or more per week during a 12 month period standard measurement period, as defined by the Patient Protection and Affordable Care Act of 2010, as amended;
Waiting Period:	One month from the date of eligibility, or, if the employee is a new variable hour employee, the first day of the month subsequent to the last day of the 12 month standard measurement period
Eligible Spouses and Dependents:	Spouse and Dependents meeting certain requirements.
Use of Social Security Numbers:	<p>Please note the following important information about the use of Members Social Security numbers. Federal law (Title XI, Section 1144 of the Social Security Act, Medicare - Medicaid Coverage Data Bank) requires the use of Members tax identification numbers (or Social Security numbers) to identify Members under the South Dakota State Employee Health Plan. Under this law, each year the State must provide the Centers for Medicare and Medicaid Services (CMS) a list of the individuals covered under the South Dakota State Employee Health Plan. CMS uses this information to determine if Medicare recipients have primary healthcare coverage elsewhere.</p> <p>The required list includes all Plan Members.</p> <p>The South Dakota State Employee Health Plan assigns random identification (ID) numbers, which are printed on the Member's State Health ID card.</p>
Self-Funded Health Plan:	<p>Financial risks taken and the obligation to pay claims are the responsibility of the self-insured South Dakota State Employee Health Plan, which is funded through a combination of State dollars and Employee contributions. The South Dakota State Employee Health Plan receives no federal-source funding.</p> <p>The South Dakota State Employee Health Plan became self-insured in 1991. It was determined to be the least costly and most efficient way to make a health plan available to State Employees and their families.</p>

The Bureau of Human Resources administers the South Dakota State Employee Health Plan. One of the responsibilities of the Plan Administrator is to hire companies with expertise, manpower, and computer systems to enhance benefits and quality of service for Members.

The South Dakota State Employee Health Plan uses several vendors that are called “third party administrators.” Vendors provide only administrative services. The vendors do not assume any financial risk or obligation with respect to claims.

Non-Grandfathered Status:

The South Dakota State Employee Health Plan is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). The Plan meets minimum value as defined

State Benefit Philosophy:

The South Dakota State Employee Health Plan is a self-funded plan. Everyone participating in a Plan is a “stakeholder,” with a personal stake in Plan costs, contribution levels, and benefit coverage.

State:

- Work with Providers to offer comprehensive coverage to Eligible Employees, Retired Employees, and COBRA Members.
- Provide tools and resources to support good health for Members.
- Coordinate with Third Party Administrators.

Members:

- Understand plan options.
- Make informed decisions.
- Maintain good health.

Provider:

- Provide high-quality, competitively priced programs, and service.

Working together to make educated and healthier choices will ensure higher quality care and cost savings for Members.

How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information

Our Legal Duty/HIPAA Notice of Privacy Practices

We are required by law to protect the privacy of your health information. We are also required to provide you with this Notice of Privacy Practices, which explains how we may use information about you and when we can give out or “disclose” that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms in this notice.

The terms “information” and “health information” in this notice

include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. If we make a material change in our privacy practices, we will provide you a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice on your health plan website, www.benefits.sd.gov. We reserve the right to make any revised or changed notice effective for information that we already have and for information that we receive in the future.

How the Plan Uses and Discloses Health Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for health care services and to administer the health plan. We may use or disclose health information:

- For Payment of health services you receive. For example, we may tell a physician whether you are eligible for coverage and what percentage of the bill may be covered.
- For Treatment. We may use or disclose information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help provide medical care to you.
- For Health Plan Administration. We may use or disclose health information as necessary to administer and manage activities related to providing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve plan services.
- To Provide You Information on Health Related Programs or Products such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law. For example, we may provide you with information about managing a disease or information on managing care choices or information about prescription drugs you are taking.
- For Reminders. We may use or disclose health information to send you reminders about your benefits or care, such as

appointment reminders with providers who provide care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- As required by law. We may disclose information when it is permitted or required to do so by law.
- To Persons Involved With Your Care. We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family Member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, factors surrounding your situation assessed by the State's experts to determine if disclosure is the proper course of action to meet your best interests.
- For Public Health Activities such as reporting or preventing disease outbreaks.
- For Reporting Victims of Abuse, Neglect or Domestic Violence to government authorities that are authorized by law to receive such information, including secret service or protective service agency.
- For Health Oversight Activities to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- For Judicial or Administrative Proceedings such as in response to a court order, search warrant or subpoena.
- For Law Enforcement Purposes. We may disclose your health information to a law enforcement official for purposes such as proving limited information to locate a missing person or report a crime.
- To Avoid a Serious Threat to Health or Safety to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- For Specialized Government Functions such as military and veteran activities, national security and intelligence activities, and others.
- For Workers' Compensation as authorized by, or to the extent necessary to comply with, state Workers' Compensation laws that govern job-related injuries or illness.
- For Research Purposes such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- To Provide Information Regarding Decedents. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- For Organ Procurement Purposes. We may use or disclose information to entities that handle procurement, banking or

transplantation of organs, eyes or tissue to facilitate donation and transplantation.

- To Correctional Institution or Law Enforcement Officials if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary
 - (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- To Business Associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our Business Associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- For Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We will send notice directly to you following a breach of your unsecured protected health information.
- Additional Restrictions on Use and Disclosure. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain information, including highly confidential information about you. “Highly confidential information” may include confidential information under Federal laws, as well as state laws that often protect the following types of information:
 1. HIV / AIDS;
 2. Mental health, including psychotherapy notes;
 3. Genetic tests / information;
 4. Alcohol and drug abuse;
 5. Sexually transmitted diseases and reproductive health information;
 6. Child or adult abuse or neglect, including sexual assault; and
 7. All protected health information for use in marketing or sale, unless you provide an authorization of such use and disclosure.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information.

You may take back or “revoke” your written authorization at any time

in writing, except if we have already acted based on your authorization.

Members Rights

The following are your rights with respect to your health information:

Access -- You have the right to access and obtain a copy of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy health information. Mail your request to the address listed below. We may charge a reasonable fee for any copies. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, you will have the right to request that we send a copy of your health information in an electronic format to you or a third party that you identify subject to proper verification and security measures. We may charge a reasonable fee for sending the electronic copy of your health information.

Disclosure Accounting -- You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (1) for treatment, payment, and health care operations purposes; (2) to you or pursuant to your authorizations (3) to correctional institutions or law enforcement officials; and (4) other disclosures for which federal law does not require us to provide an accounting.

Restriction -- You have the right to ask to restrict uses or disclosures of your information for treatment, payment, and health operations. You also have the right to ask to restrict disclosures to family Members or to others who are involved in your health care or payment for your health care. We may also have policies on Spouse and Dependent access that authorize your Spouse and Dependents to request certain restrictions.

You have the right to restrict disclosures of health information to us with respect to health care for which you have paid out-of-pocket in full with the exception of some prescription fills.

Confidential Communication -- You have the right to ask to receive confidential communications of information in a different manner or at a different place. For example, by sending information to a P.O. Box instead of your home address. You must make your request in writing. Mail your request to the address listed below.

Amendment -- You have the right to ask to amend information we maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

Electronic Notice -- You have the right to receive electronic copies of health information, or any changes made to how we use or disclose your health information. You may obtain a copy of this

notice on your health plan website, www.benefits.sd.gov .

Exercising Your Rights

Contacting Your Health Plan. If you have any questions about this notice or want to exercise any of your rights, please call the toll-free Member phone number on the back of your health plan ID card or you may contact Bureau of Human Resources, Privacy Officer at 605.773.3148 or by email BHRHIPAA@state.sd.us.

Submitting a Written Request. Mail to us written requests for modifying or cancelling a confidential communication, for copies of your record, or for amendments to your record, at the following address:

Privacy Office
Bureau of Human Resources
500 East Capitol
Pierre, SD 57501

Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above. You may notify the Secretary of the U.S. Department of Health and Human Services of your complaint. Our Privacy Office can provide you the address.

We support your right to the privacy of your medical information. Under no circumstances will you be penalized or retaliated against for filing a complaint.

CONTACT INFORMATION

CONTACT INFORMATION

BUREAU OF HUMAN RESOURCES

PMB 0141-1
500 East Capitol Avenue
Pierre, SD 57501

605.773.3148

Email:

BHR.Memberbenefits@state.sd.us

Web site: <http://benefits.sd.gov>

877.573.7347 toll free

Press 1 for DAKOTACARE
Press 2 for Bureau of Human Resources
Press 3 for Health Management Partners (HMP)
Press 4 for Delta Dental
Press 5 for MetLife
Press 6 for Risty Benefits
Press 7 for Employee Assistance Program (EAP)
Press 8 for Discovery Benefits
Press 9 for Staywell

DAKOTACARE

2600 W 49th Street
Sioux Falls, SD 57105

800.831.0785 or
605.334.4000

Email:

state-customer-service@DAKOTACARE.com

Web site:

www.DAKOTACARE.com

The South Dakota State Employee Health Plan along with DAKOTACARE provide State employees with a system of Member doctors and other healthcare providers as well as processing claims for the health plan.

General Health information, including:

- Eligibility questions (for example, if a child is listed as a covered Dependent)
- Questions about claims processing, appeals, coordination of benefits, or third party liabilities
- Covered expenses and benefit level information
- Deductible and out-of-pocket expense information
- Plan limitations and exclusions

Health Plan information, including:

- A list of DAKOTACARE and Sanford medical providers
- Additional I.D. cards
- Health Home Pilot Program

DAKOTACARE Access – View EOB Information Online. DAKOTACARE Access allows secure electronic access to personal DAKOTACARE-related claim information for the Health Plan: <http://benefits.sd.gov>, click Active Employee, scroll over Forms/Documents, click Contacts and Resources, and choose DAKOTACARE Access

CVS Caremark

Customer Service:
866.443.1185

- Questions about the Prescription Network
- Formulary, Preventive Formulary and Maintenance Listing

Website: www.caremark.com

HEALTH MANAGEMENT PARTNERS (HMP)

2301 West Russell Street
Sioux Falls, SD 57104
866.330.9886 or
605.333.9886

Website:

<https://sosd.hmpsportal.com>

Pre-auth: www.preauthonline.com

www.connect.eviti.com

for oncology requests

- Pre-authorization for Hospital confinement or other health services requiring Pre-authorization
- Condition Management: Register online at <https://sosd.hmpsportal.com>
- Our Healthy Baby: Register online at <https://sosd.hmpsportal.com>
- Questions about managed care
- Case Management for Oncology, Complex Cases, Pediatric cases, Neonatal Intensive Care, Transplants, and Bariatric. For more information call: 866.330.9886

DISCOVERY BENEFITS

4321 20th Avenue S
Fargo, ND 58103

866.451.3399

Website:

<https://www.discoverybenefits.com/>

- Flexible Spending Accounts, Health Savings Accounts, Health Reimbursement Accounts

PRIVATE HEALTH CARE SYSTEMS (PHCS/Multiplan) Healthy Directions Network

888.865.7427

Website: www.multiplan.com

- Nationwide Provider Directory
 - Select PHCS Healthy Directions

WORDS AND PHRASES

Some terms used in the Plan are defined below. Other terms may be explained where used in another part of the Plan.

- (a) **“Acute Rehabilitation Facility”** - An institution operated pursuant to law for the purpose of providing Rehabilitation Therapy.
- (b) **“Accidental Injury of Injury”** – Some type of bodily harm sustained in an accident during the period of coverage.
- (c) **“Annual Enrollment Period”** - The period before the beginning of a Plan Year when State Employees may elect coverage, change Plans, or make other changes to the existing healthcare coverage. See “Special Enrollment” for information about existing State Employees adding a Spouse and Dependents coverage during the Annual Enrollment Period.
- (d) **“Allowed Amount”** – Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference (See Balance Billing).
- (e) **“Appeal”** - A request for your health insurer or plan to review a Claim Administrators decision or a grievance in accordance with the Plan’s multi-level appeal procedures.
- (f) **“Approved Clinical Trial”** – A Phase I, II, III, or IV clinical trial that is conducted for the prevention, detection, or treatment of cancer or other disease or condition likely to lead to death unless the course of the disease or condition is interrupted and is one of the following:
 - 1) federally funded; or
 - 2) conducted under an investigational new drug application (IND) or;
 - 3) is a drug trial exempt for IND application requirements.
- (g) **“Balance Billing”** – When a provider bills you for the difference between the provider charges and the allowed amount. For example, if a provider charges \$100 and the Allowed Amount is \$70, the provider may bill you for the remaining \$30. A Preferred Provider (DAKOTACARE Network) may not balance bill you for covered services.
- (h) **“Benefit Maximum”** - The maximum benefit paid per Member for specific services. See “Master Schedule” and “Benefit Maximum” for listing of services.
- (i) **“Biologically-Based Mental Illness”** - Any mental illness which current medical research affirms is caused by a neurobiological disorder of the brain; which substantially impairs perception, cognitive function, judgment, and emotional stability; and which limits the life activities of the person with the illness. The term includes schizophrenia, schizoaffective disorder, bipolar affective disorder, major depression, obsessive-compulsive disorder, and other anxiety disorders, which cause Significant Impairment of Function, and other disorders proven to be Biologically-Based Mental Illnesses.
- (j) **“Body Mass Index (BMI)”** - A formula that uses weight and height to measure body fat and health risks. A BMI between 18.5 and 24.9 is typically considered a healthy weight range for that

individual's height. A BMI between 25 and 29.9 means the individual is considered overweight. And if the figure is 30 or greater, the individual is considered obese, with an abnormally high proportion of body fat, and should talk with his or her doctor about losing weight to decrease health risks.

- (k) **“Chiropractor”** – A chiropractic Physician licensed pursuant to SDCL Chapter 36-5 and who has entered into a service agreement with DAKOTACARE or its designated contractual network.
- (l) **“Claims Administrator”** - The person or persons designated by the Bureau of Human Resources to receive, process, and determine all claims submitted by Members under this Plan. Currently, DAKOTACARE is the Claims Administrator for the South Dakota State Employee Health Plan.
- (m) **“COBRA”** – The Consolidated Omnibus Reconciliation Act of 1985 and amended thereafter.
- (n) **“Coinsurance”** – Your share of the costs of covered health care service, calculated as a percentage (for example, 25%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe.
- (o) **“Continuing Employee”** -- An employee who is rehired and has a break of employment less than 13 weeks if a Central government employee or less than 26 weeks if a Board of Regent employee
- (p) **“Copayments” or “Copays”** – A fixed amount (for example, \$15) you pay for a covered health care service or prescription benefit, usually when you receive the service. The amount can vary by the type of covered health care service.
- (q) **“Coordination of Benefits”** – A provision establishing an order in which plan pays their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plan do not exceed total allowable expense.
- (r) **“Creditable Coverage”** – Defined in SDCL 58-17-69, “...benefits or coverage provided under:
 - 1) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan or an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 as adopted by the director pursuant to chapter 1-26, to the extent that the plan provides directly or through insurance, reimbursement or otherwise to employees, their Spouse or Dependents medical care for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body and amounts paid for the transportation primarily for and essential to medical care;
 - 2) An individual health benefit plan, including coverage issued by any health maintenance organization or pre-paid hospital or medical services plan that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan as approved pursuant to chapter 1-26, but excluding limited benefit plans and dread disease plans;
 - 3) Medicare or Medicaid;
 - 4) Chapter 55 of Title 10, U.S.C.;
 - 5) A medical care program of the Indian Health Service or of a tribal organization;

- 6) A state health benefits risk pool;
- 7) A health plan offered under Chapter 89 of Title 5, U.S.C.;
- 8) A public health plan;
- 9) A health benefit plan under Section 5(e) of the Peace Corps Act 22 U.S.C. 2504(e);
- 10) A church plan;
- 11) A college plan;
- 12) A short term or limited duration plan; or
- 13) An individual health benefit plan, including coverage issued by any health maintenance organization or pre-paid hospital or medical services plan that provided benefits less than the benefits provided under the basic health benefit plan as approved pursuant to chapter 1-26, but excluding the following excepted benefits:
 - (a) Coverage only for accident including accidental death and dismemberment;
 - (b) Disability income insurance;
 - (c) Liability insurance including general liability insurance and automobile liability insurance;
 - (d) Coverage issued as a supplement to liability insurance;
 - (e) Workers' compensation or similar insurance;
 - (f) Automobile medical payment insurance;
 - (g) Credit only insurance including mortgage insurance;
 - (h) Coverage for on-site medical clinics; and
 - (i) Limited scope dental and long-term care insurance, if provided under a separate policy, certificate, or contract of insurance, or not otherwise an integral part of a plan.

A newly-hired otherwise Eligible Employee is not required to provide proof of Creditable Coverage, or satisfy any special waiting period in order to enroll in the Plan.

- (s) **“Custodial Care”** - A level of care which:
 - 1) Cannot reasonably be expected to greatly restore health;
 - 2) Is mainly made up of non-skilled nursing services; and

- 3) Is chiefly designed to assist a person in coping with the activities or problems of daily living - such as training or assistance with personal hygiene and other self-care activities. (Custodial care may be given in an at-home setting or in a nursing home or Extended Care Facility.)
- (t) **“Deductible”** – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. The Deductible may not apply to all services, such as preventative services.
 - (u) **“Dependent”** - Means the following, as long as such person is not otherwise eligible to be covered as an Employee under the Plan; or, if such person was previously eligible, is no longer eligible because of a disability:
 - 1) Each of the Employee’s children who is:
 - a) Under the age of 26 or under the age of 29 if a Full-Time Student. For purposes of life Coverage, benefits shall cease for a Dependent Child on the last day of the month in which each child attains age 26, or age 29 if a Full-Time Student if applicable premium is paid; or
 - b) Not in military service.

The term “children” means children by birth, adopted children, children who have been placed for adoption, stepchildren, or children who live with the Employee in a legal parent-child relationship (legal guardianship).

Newborn children of an employee may be covered at birth provided the Plan is notified within 60 days after the day of the birth and the appropriate premium is paid.

Notwithstanding the above, “Dependent” also includes an eligible Employee’s child named as an alternate recipient with respect to such Eligible Employee under a Qualified Medical Child Support Order (QMCSO) (as defined in ERISA Section 609(a)(2)(A)).

- (v) **“DRG (Diagnosis-Related Group)”** - A Hospital reimbursement system first implemented by the Medicare program. The reimbursement amount typically is based on a pre-determined classification of diagnoses, treatments, age, sex, and discharge status of Patients. Under the South Dakota State Employee Health Plan, this pre-determined rate of reimbursement is based on an average cost for a service and agreed to by the provider and the State. Also called “Diagnostic Related Group.”
- (w) **“DRG Payment Method”** - An approach that bases payment for acute Hospital inpatient services on the DRG system of classifying Patients.
- (x) **“Drug Formulary”** – A compilation of therapeutically effective prescription drugs that are accepted by the South Dakota State Employee Health Plan for treatment of Members. Within a particular therapeutic category, some, but not all brand-name and generic drugs may be included. The prescription medications, which are included on the Drug Formulary, may be amended by the South Dakota State Employee Health Plan at any time without notice to the Member. To view the formulary, visit <http://benefits.sd.gov/Forms.aspx> and click FY17 Formulary located in the Pharmacy section.

- (y) **“Durable Medical Equipment (DME)”** – Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include but are not limited to: oxygen equipment, wheelchairs, or crutches.
- (z) **“Eligible Employee”** – A permanent full-time employee, permanent part-time employee, a retiree under 65 years of age, or an employee employed by a participating unit who has worked an average of 30 hours or more per week during a 12 month standard measurement period, as defined by the Patient Protection and Affordable Care Act of 2010, as amended.
- (aa) **“Emergency Services”** - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
- (bb) **“Enrollment Date”** – The first day of coverage, or if there is a waiting period, the first day of the waiting period.
- (cc) **“Experimental or Investigational Treatment”** - A drug, medicine, device, medical technology, medical treatment, or procedure that meets one or more of the following criteria:
 - (1) A drug, medicine, or device which cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval of marketing has not been given at the time the drug or medicine or device is furnished; or
 - (2) Reliable Evidence shows that the drug or medicine, device or medical treatment or procedure is not the subject of on-going phase I, phase II or phase III clinical s; or
 - (3) A drug, medicine, device, medical technology, medical treatment, or procedure which has not been approved through DAKOTACARE’s New Technology Review Process.
- (dd) **“Extended Care Facility (ECF)”** - An institution, which:
 - 1) Is operated pursuant to law;
 - 2) Is approved as a skilled nursing facility for payment of Medicare benefits or qualified to receive that approval, if requested;
 - 3) Is primarily engaged in providing room and board and skilled nursing care under supervision of a Physician;
 - 4) Provides continuous 24 hour a day skilled nursing care by or under supervision of a registered nurse (RN); and
 - 5) Maintains a daily medical record of each Patient.

Coverage under this Plan at an ECF is limited to sixty (60) days per Plan Year.

A home, facility, or part of a facility does not qualify as an ECF if it is used primarily for:

- 1) Rest;
- 2) The care of drug abuse or alcoholism;

- 3) The care of mental diseases or disorders; or
 - 4) Custodial or educational care.
- (ee) **“FMLA”** – The Family Medical Leave Act of 1993 and amendments thereto.
- (ff) **“Full Time Student”** – Full time status is defined by each higher education institution. Example: A Dependent taking 12 credits as an undergraduate, 9 credits as a graduate, or considered a Full-Time Student by the educational institution.
- If ineligible, the Dependent must be removed from the plan. Example of removal dates:
- 1) Graduation: End of the month in which graduation occurs;
 - 2) Cease full-time status mid-year: End of the month in which last a full-time student;
 - 3) Student verification not received for Spring semester: End of the month in which the last a Full-Time Student, example December 31; and
 - 4) Student verification not received for fall semester: End of the month in which most recently a full-time student, example May 31.
- Note: Coverage is not lost during summer months, if student status continues from spring to fall semester.
- (gg) **“GINA”** – Genetic Information Nondiscrimination Act of 2008 and amendments thereto.
- (hh) **“Health Coverage”** - All coverage available under the South Dakota State Employee Health Plan.
- (ii) **“HIPAA”** – The Health Insurance Portability and Accountability Act of 1996 and amendments thereto.
- (jj) **“Home Health Agency”** - Means:
- 1) An agency licensed as a Home Health Agency by the State in which home healthcare services are provided; or
 - 2) An agency certified as such under Medicare; or
 - 3) An agency approved as such by the Plan Administrator.
- (kk) **“Home Health Care”** – Health care services a person received at home.
- (ll) **“Hospice”** – A facility or program engaged in providing palliative and supportive care of the terminally ill.
- (mm) **“Hospital”** - An institution which:
- 1) Is operated pursuant to law for the provision of medical care;
 - 2) Provides continuous 24 hour a day nursing care under the supervision of a staff of Physicians;
 - 3) Has facilities for providing diagnostic and therapeutic services to diagnose, treat, and care for injured, disabled, or sick individuals who need acute inpatient care;

- 4) Has facilities for major surgery; and
- 5) If required, is licensed as a Hospital.

But, an institution primarily concerned with the treatment of chronic disease does not need to have facilities for major surgery, if it otherwise qualifies, as provided above.

“Hospital” also means an ambulatory surgical center, which is operated pursuant to law, including licensed mobile units.

For treatment of alcoholism and drug abuse only, “Hospital” also means:

- 1) A treatment or residential facility; or
- 2) A clinic.

Such facilities must be licensed or approved by the appropriate authority for these purposes in the jurisdiction in which they are located.

“Hospital” does not include a:

- 1) Rest home;
- 2) Nursing home;
- 3) Convalescent home;
- 4) Place for Custodial Care;
- 5) Home for the aged;
- 6) Institution that primarily furnishes training for medical students; or
- 7) A Doctor’s office or clinic, which is equipped to perform minor surgery.

(nn) **“Hospital Admission”** - Entering a Hospital as an inpatient and incurring a room and board charge, whether for observation or treatment. Each admission to a Hospital will be deemed a separate Hospital Admission, unless the Patient is readmitted to the Hospital for the same condition within 7 days.

(oo) **“Hospital Stay”** - If a person:

- 1) Incurs a Hospital room and board charge for Medically Necessary inpatient care, whether for observation or treatment;
- 2) Receives emergency care at a Hospital for an Injury not later than 72 hours after the onset of the Medical Emergency or the Injury occurs;
- 3) Undergoes surgery at a Hospital; or

4) Treatment for alcoholism or drug abuse at a Hospital.

Unless it is an emergency or a “normal” maternity admission, inpatient Hospital stays must be pre-authorized by HMP before the Patient is Hospitalized.

(pp) **“Incapacitated Dependent”** – An Incapacitated Dependent must:

1) Be incapable of self-support because of intellectual disability or any other mental or physical disability;

2) Become incapacitated prior to attaining the limiting age for coverage of children; and

3) Remain Dependent upon the insured parent or guardian for support and maintenance (meets the Internal Revenue Service (IRS) requirements for Dependents for federal income tax purposes). Refer to website: <http://www.irs.gov/publications/p501/ar02.html#d0e853>.

(qq) **“Incurred”** - A charge is deemed “Incurred” on the date the service or supply is provided.

(rr) **“Injury”** - Only bodily Injury sustained accidentally by external means.

(ss) **“Legal Guardian”** – A person appointed by a court to be responsible for the personal affairs of a minor or protected person.

(tt) **“Maximum Allowable Charge (MAC)”** - The charge a provider agrees to accept, in lieu of the usual, reasonable, and customary charge, as a condition of becoming a participating network provider. Employees should not be billed for more than the “Maximum Allowable Charge” by a participating provider.

(uu) **“Medical Emergency”** - A sudden and unexpected onset of a medical condition causing the person to seek medical care and treatment promptly or within a reasonable time after the onset.

(vv) **“Medically Necessary”** – Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

(ww) **“Member”** – Any Employee, Spouse or Dependent who is insured under the Plan.

(xx) **“Morbid Obesity”** - The point at which there is immediate health risks from the condition of obesity. This includes the likelihood of developing a number of potentially serious health problems such as hypertension (high blood pressure), diabetes, coronary artery disease, stroke, or severe joint disease. Under this Plan, a covered individual must also have a BMI of 40 or greater to be considered morbidly obese.

(yy) **“Non-Emergency Services”** - A Hospital Admission or medical treatment that is not an emergency admission.

(zz) **“Occupational Disease”** - A disease for which a person is entitled to benefits under a Workers’ Compensation Law or similar law.

- (aaa) **“Occupational Injury”** - An Injury which arises out of and in the course of employment for wage or profit. An Injury will not be deemed occupational if such person is not eligible for Workers’ Compensation coverage.
- (bbb) **“Office Visit”** – Covered Physician services when provided in the Physician’s office setting.
- (ccc) **“Out-of-Pocket Maximum”** – The portion of payments for health services which is the responsibility of the Member, which shall include Deductible and Coinsurance.
- (ddd) **“Patient”** - Any Employee, Spouse or Dependent who is insured under the Plan and to whom the Managed Care Program applies.
- (eee) **“PPACA”** - Patient Protection and Affordable Care Act of 2010 and amendments thereto.
- (fff) **“Patient’s Representative,”** –
 - 1) Patient’s relative, friend, or guardian;
 - 2) Patient’s Physician; or
 - 3) A representative from an institution providing care to the Patient.
- (ggg) **“Pharmacy Network”** - A group or groups of pharmacies who have contracted with the State to provide services to Plan Members and who the State has designated as participating, or network, providers. Currently, pharmacies participating in the CVS Caremark Pharmacy Network are considered participating pharmacies.
- (hhh) **“Physician”** - One who is licensed as such while acting within the scope of that license. The following licensed practitioners shall be considered “Physicians”:
 - 1) Doctor of Chiropractic (D.C.);
 - 2) Doctor of Dental Surgery (D.D.S.);
 - 3) Doctor of Medicine (M.D.);
 - 4) Doctor of Ophthalmology (M.D.);
 - 5) Doctor of Optometry (O.D.);
 - 6) Doctor of Osteopathy (D.O.);
 - 7) Doctor of Podiatry (D.P.M.);
 - 8) Doctor of Psychiatry (M.D.); and
 - 9) Doctor of Psychology (Ph.D.).

“Physician” also includes Nurse Practitioners, Certified Nurse Midwife, spiritual healers, Certified Social Workers (CSW), Social Workers (SW), and Social Worker Associates (SWA) who have the Private Independent Practice (PIP) designation.
- (iii) **“Pre-authorization”** –A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or Durable Medical Equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require Pre-authorization for certain services before you receive them, except in an emergency. Pre-authorization isn’t a promise your health insurance or plan will cover the cost.

- (jjj) **“Preventive Care”** – Care received to prevent illness and disease. Preventive Care includes things such as routine cancer screenings, well-child care, and immunizations. The term “Preventative Care” also includes care and treatment designated or identified as such in federal regulations promulgated by the Department of Health and Human Services under the PPACA.
- (kkk) **“Pregnancy”** - The condition of being pregnant and childbirth as well as related medical conditions.
- (lll) **“Primary Care Provider”** - A physician (M.D.-Medical Doctor or D.O. Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.
- (mmm) **“Qualified Medical Child Support Order (QMCSO)”** - A Qualified Medical Child Support Order is a court order used to enforce an order for a health plan Member to provide child support health benefits. It requires a health plan to include a child as covered under a health plan, even if the child(ren) or the Member do not meet the conditions of the health plan. A QMSCO is typically used to gain coverage for a child under a non-custodial parent's group health plan. It is normally obtained by a divorced or separated Spouse or by a state child support or Medicaid agency. The order authorizes withholding the Member's share of the cost for coverage from their pay. They may not drop coverage for the child without proof that the QMSCO is no longer in effect.
- (nnn) **“Qualified Mental Health Professional (QMHP)”** - A Qualified Mental Health Professional (QMHP) is a professional “endorsed by the South Dakota Department of Human Services (SDCL 27A-1-7). Only a QMHP may do the examination required as part of an involuntary mental illness commitment process (27A-10-6). Physicians licensed pursuant to SDCL 36-4 are considered Qualified Mental Health Professionals and are not required to receive the endorsement. Individuals eligible for endorsement are those listed in SDCL 27A-1-3:
- A psychologist who is licensed to practice psychology in the state where services are received;
 - A psychiatric nurse with a master’s degree from an accredited training program and two years of supervised clinical experience in a mental health setting;
 - A certified social worker with a master’s degree from an accredited training program and two years of supervised clinical experience in a mental health setting;
 - A person who has a master’s degree in psychology from an accredited program and two years of supervised clinical mental health experience and who meets the provision of Subdivision 36-27A-2 (2); or
 - A counselor who is certified under SDCL chapter 36-32 as a licensed professional counselor-mental health (LPC-MH).
- (ooo) **“Quantity Level Limit (QLL)”** – The maximum dosage of units supplied of a prescription medication that a Member may receive at one time based on recognized standards of safety and clinical dosing guidelines.
- (ppp) **“Rehabilitation Therapy”** - A series of procedures or treatments provided in a Hospital, Extended Care Facility (ECF) or Acute Rehabilitation Facility, which will enable an injured or ill person to carry on the regular and customary activities of a person of the same age and sex.
- (qqq) **“Retired Employee”** - A former Employee who is covered under the Health Coverage plan provided under SDCL 3-6E on his or her date of retirement. The Retired Employee must also be entitled to immediate retirement benefits as a Class A or Class B Member of the South Dakota

Retirement System or the South Dakota Department of Labor Retirement Plan as outlined in SDCL 3-12-91, SDCL 3-12-92 and SDCL 61-2-15.

Medicare is primary to the State Plan for retired Members and Spouses. Medical coverage under this Plan ends the first of the month in which the retired Member and/or his or her Spouse turn age 65. At that time coverage may be converted to a Medicare Supplement Plan.

- (rrr) **“SDCL”** – South Dakota Codified Laws.
- (sss) **“Significant Impairment of Function”** - A mental or nervous condition that creates significantly increased risk of suffering death, pain, disability, or an important loss of freedom. This would include a person who, as a result of mental illness:
- 1) Is in danger of serious physical harm due to the inability to provide essential human needs for food, clothing, shelter, or medical care;
 - 2) Lacks judgment in the management of resources and in the conduct of social relations to the extent that health or safety is significantly endangered; or
 - 3) Needs continued therapeutic treatment and support in order to maintain functioning above the levels noted above.
- (ttt) **“Special Enrollment Period”** – A period made available to an Eligible Employee, his/her Spouse, and or Dependents who have previously declined coverage in writing stating that the employee, Spouse and or Dependents had other health insurance coverage at the time of initial eligibility. The Special Enrollment Period applies when the employee, Spouse or Dependent was:
- 1) Covered under other Creditable Coverage at the time of the initial eligibility, and
 - 2) The previous coverage is either:
 - i) Continuation coverage that is exhausted; or
 - ii) Other Creditable Coverage is terminated due to loss of eligibility or termination of employer contributions to the coverage.
- A request for participation under this clause must be made within sixty-three (63) days of the date of termination of the previous coverage.
- A Special Enrollment Period is also available to a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption. You may be able to enroll your Spouse and or Dependents, provided you request enrollment within 60 days following the date of the event.
- (uuu) **“Specialty Injectable Medication”** – High-cost, biotech drugs used to treat long-term or chronic diseases, which are administered by subcutaneous injection, intramuscular injection, or intravenous infusion.
- (vvv) **“Specialty Medications”** – Scientifically engineered medications that are prescribed to Patients with complex diseases that may include rheumatoid arthritis, growth deficiencies, multiple sclerosis, or cancer. The medications tend to be the product of innovative technology, high cost, and require special handling and administration. Types of specialty medications may include, but

are not limited to: self-administered injectable drugs administered by the Patient or the Patient's caregiver in a home setting; office-administered injectable drugs administered by a healthcare professional in non-Hospital setting; inhalation agents for non-cancer treatments; and high cost oral agents.

(www) **“Spouse”** – An Employee's husband or wife as a result of marriage that is legally recognized in South Dakota or under the laws of the State where the marriage occurred. The Spouse in a common-law marriage is not eligible to be covered on the plan.

(xxx) **“Surgical Procedure”**

- 1) A cutting procedure;
- 2) Suturing of a wound;
- 3) Treatment of a fracture;
- 4) Reduction of a dislocation;
- 5) Radiotherapy, excluding radioactive isotope therapy, if used in lieu of a cutting operation for removal of a tumor;
- 6) Electrocauterization;
- 7) Diagnostic and therapeutic endoscopic procedures; and
- 8) An operation by means of laser beam.

(yyy) **“Tier 1”** – Tier 1 is a benefit for all covered Members of the health plan that will reduce the cost associated with certain cardiac, orthopedic, bariatric, renal care and gastroenterology services. Tier 1 is based on the service, facility, and provider. To receive the highest level of benefit, you must have a Tier 1 service performed at an approved Tier 1 facility by an approved Tier 1 provider. Tier 1 facilities and providers will provide high quality care at a set rate for provider, anesthesia, lab work, pathology, and x-ray services for a Tier 1 service. The services a Member receives at a Tier 1 facility three days prior and 30 days after the procedure or discharge are covered at a set rate. In cases of a Tier 1 Bariatric procedure the set rate for services is a 365 day period. Rapid City Regional and Spearfish Regional Tier 1 rates apply to the facility bill only.

(zzz) **“Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and amendments thereto”**-- The Uniformed Services Employment and Reemployment Rights Act of 1994 was signed into law on October 13, 1994 to protect the civilian employment of non-full-time military personnel in the United States called to active duty

(aaaa) **“Usual, Customary and Reasonable (UCR)”** – The amount paid for a medical service in geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

(bbbb) **“Utilization Review Organization (Health Care Management Company)”** - The independent entity, group, or individual selected by the Bureau of Human Resources to carry out the State Managed Care Program. Currently, Health Management Partners (HMP) is the State Health Care

Management Company and Utilization Review Organization for medical services, treatment, and supplies. At its discretion, the State may designate some other company to perform this function.

- (cccc) **“Waiting Period”** – A waiting period is the amount of time a Member must wait before their coverage begins. The waiting period for a new hire or a rehire who is not a continuing employee is one month. The waiting period for a continuing employee is the time from when they are hired to the first day of the month following their hire.
- (dddd) **“Written Notice”** - A notice in writing on a form supplied by or which satisfies the Plan Administrator.

MASTER SCHEDULE – \$750 DEDUCTIBLE PLAN

The Plan Year begins on July 1st and ends on June 30th of the following year. All benefits described in this Schedule are subject to the exclusions, limitations, and other provisions of the Plan described in detail with in this document.

QUALIFYING FOR THE LOWEST DEDUCTIBLE HEALTH PLAN

To qualify for the lowest deductible plan in FY18, employees and covered Spouses must complete a Health Screening, a Health Assessment, and earn 100 Wellness Points during FY17.

PLAN YEAR DEDUCTIBLE

Members in the \$750 Deductible Plan must satisfy a Plan Year \$750 individual Deductible or \$1,875 family Deductible for care received in-network from DAKOTACARE or Sanford providers. Coinsurance applies after Deductible is satisfied.

The Family Deductible applies only to families with three or more covered family Members enrolled in the same Plan.

The Plan will begin paying benefits for each individual as soon as the per person Deductible is met. The Family Deductible is satisfied when at least three family Members have medical expenses that total the Family Deductible amount. No one family Member can meet the entire Family Deductible.

Only charges which apply to the individual Deductible are applied to the Family Deductible. Coinsurance cannot be used to satisfy the Family Deductible.

HOW THE DEDUCTIBLE IS SATISFIED

A Member can satisfy the Deductible by incurring covered charges in an amount equal to the Deductible within the Plan Year.

The Deductible applies separately to each Member, except:

- (a) If any three or more Members enrolled in the same Plan, satisfy the Family Deductible for the same Plan Year. One Member cannot meet the Family Deductible in the \$750 Deductible Plan.

Only charges which apply to the individual Deductible are applied to the Family Deductible.

The Plan will begin paying benefits for each Member as soon as the individual Deductible or Family Deductible is met.

- (b) If maternity charges are Incurred for a mother and newborn child during the birth of the child, one Deductible and Coinsurance applies to the eligible facility charges for both individuals— if they are discharged from the Hospital at the same time.
 - 1. If mother is not in this Plan and newborn is enrolled in this Plan—submit copy of explanation of benefit from mother's plan showing deductible was applied for newborn child's Deductible to be waived.
 - 2. If newborn child is not enrolled in this Plan and mother is enrolled in this Plan—newborn child's facility claim must be manually submitted with a request for newborn child's charges to be placed under the mother's charges.

MASTER SCHEDULE – \$750 DEDUCTIBLE PLAN

HOW THE DEDUCTIBLE IS SATISFIED CONTINUED

In the event of a birth by a Dependent mother, one Deductible and Coinsurance applies to the eligible charge for the Dependent mother. The charges in connection with a newborn of a Dependent mother are not covered.

Non-covered charges do not apply to the Deductible. This includes charges above the UCR charges or the Plan MAC. The cost difference when a Member chooses a provider, service or supply that is not an approved provider, service or supply by the plan does not apply to the deductible.

If a Member elects COBRA and changes from the \$750 Deductible Plan to the \$1,800 Deductible Plan, eligible Copayments and Coinsurance applied during the Plan Year while under the \$750 Deductible Plan will apply to the annual Deductible.

COMBINED FAMILY DEDUCTIBLE

Under the \$750 Deductible Plan families with both Spouses employed by the State, may combine their plans to meet the family Deductible.

Criteria:

- 1) Married;
- 2) Both Spouses employed by State of South Dakota and/or Board of Regents;
- 3) Both Spouses elected the same Plan;
- 4) Coverage level:
 - a) One Spouse is covered as single and
 - b) One Spouse is covered with Dependent(s); and
- 5) Request must be submitted during annual enrollment asking BHR to combine Deductibles.

Complete the following to request combined family Deductible:

- 1) Send an email to BHR.Memberbenefits@state.sd.us;
- 2) Include:
 - a) Employee name, Health Plan ID #, and plan (\$750) and
 - b) Spouse name, Health Plan ID #, and plan (\$750);
- 3) Indicate which Employee covers Dependent(s) on the Health Plan; and
- 4) Include a statement asking BHR to combine Deductibles.

COINSURANCE AND COPAYMENTS

Once the Deductible is satisfied, the Member pays a percentage of the allowable costs (the “Coinsurance” or “Benefit Percentage”). A Member pays an Emergency Room (ER) Copayment each time services are rendered. The ER Copayment is payable first and not applied toward the Deductible. ER Copayment is waived if admitted as Inpatient.

The type of service received and the provider used determines the benefits covered by the Plan and whether Copayments or Coinsurance are payable. If care is managed by the Physician and coordinated through the DAKOTACARE or Sanford network of providers, Coinsurance is 25%, when applicable. If care is provided out-of-network, the Member must meet a \$1,500 Deductible and Coinsurance increases to 35% for most covered expenses. The Member also pays any charges above UCR or MAC.

MASTER SCHEDULE – \$750 DEDUCTIBLE PLAN

NOTE: If a Plan Member is Hospitalized over two Plan Years (for example from June 26 to July 3), a Deductible and Coinsurance carryover policy will apply for the facility charges. The Plan Member will not have to pay an additional Deductible for a period of confinement continuing into the new Plan Year. Charges for the Hospitalization will apply to the first year's Out-of-Pocket Maximum. Professional/Ancillary charges incurred during the hospitalization will be processed according to the Plan Year of the incurred date of service. Expenses Incurred after the Hospitalization will apply to the new Plan Year limit.

LIFETIME BENEFIT MAXIMUMS

Lifetime benefit maximums per person exist for the following:

- (a) Organ Procurement for Transplant: \$50,000
- (b) Diagnosis and Treatment:
 - 1) Temporomandibular Joint Syndrome (TMJ): \$5,000
 - 2) Gastric Bypass Surgery and Similar Types of Surgery: 1 per person
 - 3) Ossatron Lithotripsy (Shock Wave Treatment for Chronic Plantar Fasciitis): \$5,000
- (c) Infertility Assistance: \$3,000 for diagnosis and medical treatment
 - 1) Excludes infertility drugs

Most of these services must be pre-authorized and be performed at a preferred contracted facility.

BENEFIT PERCENTAGES (COINSURANCE)

The Coinsurance payment is the percentage of covered charges paid by the Member after the Deductible is satisfied. Coinsurance percentages are determined by the provider used.

Members should select a DAKOTACARE or Sanford Primary Care Provider to manage and coordinate care for themselves, a Spouse and Dependents. Physicians may include: family practitioners, general practitioners, general internists, general pediatricians or OB GYN.

If Members use a DAKOTACARE or Sanford Network provider, the Member is responsible for the Deductible then 25% Coinsurance. If Members use a non-DAKOTACARE or non-Sanford Network provider, the Member is responsible for the Out-of-Network Deductible then 35% Coinsurance.

Primary care providers provide basic or routine services, Preventive Care, and will refer Patients to participating DAKOTACARE or Sanford specialists or Hospitals as necessary. In some cases, a DAKOTACARE or Sanford specialist may require a referral from your Physician before an appointment is scheduled.

If chiropractors participating in the DAKOTACARE Network are used, the Member is responsible for Deductible, then 25% Coinsurance.

If non-DAKOTACARE Network chiropractors are used, the Member is responsible for the Out-of-Network Deductible, then 35% Coinsurance and is responsible for charges over UCR or MAC.

MASTER SCHEDULE – \$750 DEDUCTIBLE PLAN

If South Dakota Department of Health or the South Dakota Human Services Center in Yankton is used, the Member is responsible for Deductible, then 25% Coinsurance.

MEDICAL OUT-OF-POCKET MAXIMUM

The medical Out-of-Pocket Maximum is \$3,600 per person or \$8,125 per family of three or more, for covered medical expenses each Plan Year. The maximum consists of any Deductible, Coinsurance, and Copayments.

If a Tier 1 service is done at a Tier 1 facility, the Out-of-Pocket Maximum remains at \$3,600 per person or \$8,125 per family of three or more, for medical costs. If a service available at a Tier 1 facility is done at a Non-Tier 1 facility but still In-Network, the medical Out-of-Pocket Maximum is \$5,350 per person or \$10,200 per family of three or more.

When a Member receives services from Network Providers or Out-of-Network Providers, eligible charges from both will apply to the Out-of-Pocket limits. The maximum paid for eligible combined out-of-pocket expenses is \$7,200 per person or \$16,250 per family of three or more.

MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN

(Health Saving Account Compatible)

The Plan Year begins on July 1st and ends on June 30th of the following year. All benefits described in this Schedule are subject to the exclusions, limitations, and other provisions of the Plan described in detail within this document.

PLAN YEAR DEDUCTIBLE

Members in the \$1,800 Deductible Plan must satisfy a \$1,800 Single Deductible or a \$3,600 Family Deductible each Plan Year. All eligible charges, including prescription drugs, apply to Deductible. If Member has family coverage (two or more covered Members) the Family Deductible must be met before payment of benefits will begin.

The Family Deductible applies to families with two or more covered family Members enrolled in the same Plan.

The Plan will begin paying benefits as soon as the Deductible is met. The Family Deductible is satisfied when at least one or a combination of family Member has medical and pharmacy expenses that total the Family Deductible amount. One family Member can meet the entire Family Deductible.

Only charges which apply to the Single Deductible are applied to the Family Deductible. Coinsurance cannot be used to satisfy the Family Deductible.

HOW THE DEDUCTIBLE IS SATISFIED

A Member can satisfy the Deductible by incurring covered charges in an amount equal to the Deductible within the Plan Year. Single Coverage - \$1,800 Deductible, Family Coverage - \$3,600.

The Deductible applies separately to each Member, except:

- (a) One Member can meet the Family Deductible of \$3,600 when enrolled in the \$1,800 Deductible Plan with Spouse or Dependent coverage.

Only charges which apply to the Single Deductible are applied to the Family Deductible.

The Plan will begin paying benefits for each Member as soon as the Single Deductible (\$1,800) or Family Deductible (\$3,600) is met.

- (b) If maternity charges are incurred for a mother and newborn child during the birth of the child, one Deductible applies to the eligible charges for both individuals— if they are discharged from the Hospital at the same time.
 - 1. If mother is not in this Plan and newborn is enrolled in this Plan—submit copy of explanation of benefit from mother's plan showing deductible was applied for newborn child's Deductible to be waived.
 - 2. If newborn child is not enrolled in this Plan and mother is enrolled in this Plan—newborn child's facility claim must be manually submitted with a request for newborn child's charges to be placed under the mother's charges.

MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN

HOW THE DEDUCTIBLE IS SATISFIED CONTINUED

In the event of a birth by a Dependent mother, one Deductible and Coinsurance applies to the eligible charge for the Dependent mother. The charges in connection with a newborn of a Dependent mother are not covered.

Non-covered charges do not apply to the Deductible. This includes charges above UCR charges or the Plan MAC. The cost difference when a Member chooses a provider, service or supply that is not an approved provider, service or supply by the plan does not apply to the deductible.

COMBINED FAMILY DEDUCTIBLE

With IRS rules, there is no opportunity for combined Deductibles under the \$1,800 Deductible Plan.

HEALTH SAVINGS ACCOUNT (HSA)

A HSA is an account which enables the Member to pay for covered medical expenses with pre-tax dollars.

Members enrolled in the \$1,800 Deductible Plan are eligible to establish a HSA. Members may be eligible for State contribution to their HSA. A base amount will be contributed based upon the Members coverage levels. Additional contributions may be made in FY18 if the employee and covered Spouse complete a Health Screening, a Health Assessment, and earn 100 Wellness Points during FY17.

COINSURANCE

Once the Deductible is satisfied, the Member pays a percentage of the allowable costs (the “Coinsurance” or “Benefit Percentage”).

The type of service received and the provider used determines the benefits covered by the Plan and whether Copayments or Coinsurance are payable. If care is managed by the Physician and coordinated through the DAKOTACARE or Sanford network of providers, Coinsurance is 25%, when applicable. If care is provided out-of-network, the Member must meet a \$3,600 Deductible and Coinsurance increases to 35% for most covered expenses. The Member also pays any charges above UCR or MAC.

With IRS rules, there are no copayments under the \$1,800 Deductible Plan.

NOTE: If a Plan Member is Hospitalized over two Plan Years (for example from June 26 to July 3), a Deductible and Coinsurance carryover policy will apply for the facility charges. The Plan Member will not have to pay an additional Deductible for a period of confinement continuing into the new Plan Year. Charges for the Hospitalization will apply to the first year’s Out-of-Pocket Maximum. Professional/Ancillary charges incurred during the hospitalization will be processed according to the Plan Year of the incurred date of service. Expenses Incurred after the Hospitalization will apply to the new Plan Year limit.

MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN

LIFETIME BENEFIT MAXIMUMS

Lifetime benefit maximums per person exist for the following:

- (d) Organ Procurement for Transplant: \$50,000
- (e) Diagnosis and Treatment:
 - 4) Temporomandibular Joint Syndrome (TMJ): \$5,000
 - 5) Gastric Bypass Surgery and Similar Types of Surgery: 1 per person
 - 6) Ossatron Lithotripsy (Shock Wave Treatment for Chronic Plantar Fasciitis): \$5,000
- (f) Infertility Assistance: \$3,000 for diagnosis and medical treatment
 - 2) Excludes infertility drugs

Most of these services must be pre-authorized and be performed at a preferred contracted facility.

BENEFIT PERCENTAGES (COINSURANCE)

The Coinsurance payment is the percentage of covered charges paid by the Member after the Deductible is satisfied. Coinsurance percentages are determined by the provider used.

Members should select a DAKOTACARE or Sanford Primary Care Provider to manage and coordinate care for themselves, a Spouse, and Dependents. Physicians may include: family practitioners, general practitioners, general internists, general pediatricians or OB GYN.

If Members use a DAKOTACARE or Sanford Network provider, the Member is responsible for the Deductible, then 25% Coinsurance. If Members use a non-DAKOTACARE or non-Sanford Network provider, the Member is responsible for the Out-of-Network Deductible, then 35% Coinsurance.

Primary care providers provide basic or routine services, Preventive Care, and will refer Patients to participating DAKOTACARE or Sanford specialists or Hospitals as necessary. In some cases, a DAKOTACARE or Sanford specialist may require a referral from your Physician before an appointment is scheduled.

If chiropractors participating in the DAKOTACARE Network are used, the Member is responsible for Deductible, then 25% Coinsurance.

If non-DAKOTACARE Network chiropractors are used, the Member is responsible for Out-of-Network Deductible, then 35% Coinsurance and is responsible for charges over UCR or MAC.

If South Dakota Department of Health or the South Dakota Human Services Center in Yankton is used, the Member is responsible for Deductible, then 25% Coinsurance.

MEDICAL AND PHARMACY OUT-OF-POCKET MAXIMUM

The medical and pharmacy Out-of-Pocket Maximum is \$3,600 for Single coverage or any one family Member with family coverage, and \$8,125 for Family coverage of 3 or more Members each Plan Year. The maximum consists of any Deductible and Coinsurance payments.

If a Tier 1 service is done at a Tier 1 facility, the Out-of-Pocket Maximum remains at \$3,600 per person or \$8,125 per family of three or more, for medical and pharmacy costs. If a Tier 1 service available at a Tier 1 facility is done at a Non-Tier 1 facility but still in-network, the medical Out-of-Pocket Maximum for medical and pharmacy is \$5,350 per person or \$10,200 per family of three or more.

When a Member receives services from Network Providers and Out-of-Network Providers, eligible charges from both will apply to the Out-of-Pocket limits. The maximum paid for eligible combined out-of-pocket expenses is \$7,200 for Single coverage and \$16,250 for Family coverage.

HEALTH PLAN COMPARISON CHART

FY17 Health Plan Comparisons

Below is a comparison chart to help you understand the differences, similarities and costs of the two Health Plans available to you and your family.

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN COVERAGE DETAILS FOR FY17				
Plan Details	\$750 Deductible Health Plan		\$1,800 Deductible Health Plan with HSA	
	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider
Eligible Preventive Services ¹	Covered at 100%	Not covered ²	Covered at 100%	Not covered ²
Plan Year Deductible	• \$750 per person • \$1,875 per family of three or more	• \$1,500 per person • \$3,750 per family of three or more	• \$1,800 single coverage • \$3,600 family coverage per family of two or more	• \$3,600 single coverage • \$7,200 family coverage per family of two or more
			If you have family coverage, the full family deductible must be met before benefits are paid for any family member.	
Copayment	• Emergency Room: \$250		N/A	
Coinsurance	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%
Plan Year Out-of-Pocket Maximum (includes deductible)	• \$3,600 per person • \$8,125 per family of three or more	• \$7,200 per person • \$16,250 per family of three or more	• \$3,600 single coverage or any one family member • \$8,125 family coverage per family of three or more	• \$7,200 single coverage or any one family member • \$16,250 family coverage per family of three or more
Employer Health Savings Account Contribution	N/A		• \$500 for single coverage • \$1,000 for family coverage	
Prescription Drugs				
Deductible	\$50 per person	\$50 per person	Included in Plan Deductible	
Pharmacy Out-of-Pocket Maximum	• \$1,000 per person • \$2,500 per family of three or more		Included in Plan Year Out-of-Pocket Maximum	

¹ To view eligible preventive care services, visit <http://benefits.sd.gov/preventivecare.aspx>.

² When a covered Dependent attends school out-of-state, or when the Member resides out-of-state, Preventive Care services as listed are covered by the plan if member visits a PHCS provider. If Member utilizes a non PHCS provider, any charges above Usual, Customary, and Reasonable (UCR) are the Member's responsibility to pay.

ELIGIBILITY AND SELECTING COVERAGE

SELECTING COVERAGE

A new hire must select health coverage during the Initial Enrollment Period. For non-variable hour employees, the “Initial Enrollment Period” begins on the date the Employee becomes eligible and ends after 30 days of hire. For new variable hour employees, the initial 30 day enrollment period begins on the day after the expiration of the 12-month standard measurement period.

A new Employee must enroll within 30 days following the date of hire. If the Employee does not enroll, the Employee will automatically be covered under the \$1,800 Deductible Plan with no Coverage for a Spouse or Dependents.

Current Employees may elect or change coverage only during an Annual Enrollment Period through the electronic enrollment system, unless there has been a qualified change in family status. This means an Employee generally may not change the level of coverage, the plan election, or Spouse and Dependent coverage election during the Plan Year.

CHOOSING A COVERAGE LEVEL

An Eligible Employee may elect individual coverage and also may choose from six categories of Spouse and Dependent coverage:

- Employee plus Spouse;
- Employee plus child;
- Employee plus 2 children;
- Employee plus 3 or more children;
- Employee plus Spouse and 1 child; or
- Employee plus Spouse and 2 or more children.

The Employee must elect coverage in order to also enroll a Spouse and Dependents. If an Eligible Employee Opts-Out of coverage under the South Dakota State Employee Health Plan, he or she cannot elect healthcare coverage for any family Member.

As a new hire or during Annual Enrollment, an Eligible Employee may choose to Opt-Out of the State Plan providing acceptable proof of group coverage elsewhere.

See “Special Enrollment Period” and “Family Status Changes” for more information on when you may elect coverage for you or your eligible Spouse and Dependents.

WHEN COVERAGE BECOMES EFFECTIVE

Following initial enrollment, you and your enrolled Spouse and Dependents’ coverage becomes effective as follows:

- A new employee’s coverage is effective one month and one day from the date of hire.
- New variable hour employee’s coverage is effective one month and one day following the month in which the 12-month standard measurement period expires.
- A continuing employee’s coverage will begin on the first day of the month following the month in which they were rehired.

In all cases, the actual coverage effective date will be contingent on receipt of all appropriate paperwork and required contributions.

Changes during annual enrollment are effective as follows:

In the event the Employee changes coverage during the Annual Enrollment Period, this change will be effective on the first day of the Plan Year if all the required paperwork is completed and approved.

Approved changes are effective July 1st of each year.

OPTION NOT TO ELECT COVERAGE – (OPT-OUT)

Employees with current creditable group health coverage may request to Opt-Out of the South Dakota Employee Health Plan during their New Hire Enrollment Period or the Annual Enrollment Period. Proof of current creditable group health coverage must be provided to the Benefits Program to have your New Hire Enrollment Opt-Out request processed and every fiscal year during Annual Enrollment. This documentation must be on file to show an employee is currently covered by another creditable group health plan, or the \$1,800 Deductible Plan will automatically be provided for employee only coverage.

Upon receipt of acceptable proof (i.e. a signed letter written on the official letterhead or a certificate of Creditable Coverage) that an Employee has Creditable Coverage through a Spouse or another job, Members who Opt-Out of the health plan will receive an Opt-Out credit of \$300. This credit is deposited into a Health Reimbursement Account with Discovery Benefits. Members may receive reimbursement through a variety of methods and should access information through www.discoverybenefits.com.

NOTE: Other “acceptable group Health Coverage” does not include: Medicare, Medicaid, Indian Health Services, or services provided through the VA Hospital.

Employees with an active Opt-Out status at time employment ends will not be eligible for COBRA health coverage or Retiree health coverage.

RE-ENROLLING IN THE PLAN

Employees Rehired or Hours are Reduced below 30 Hours

If an Employee terminates employment and is rehired during the same Plan Year, coverages elected during the previous period of employment, and in effect at the time of termination, will be reactivated with no changes. If the Employee experiences an event that qualifies as a family status change during the months they were gone, the Employee will be allowed to make changes consistent with the event.

If an Employee’s hours are reduced below 30 hours, the Employee will be allowed to decrease coverages previously elected.

If an Employee transfers employment the coverage elected and in effect at the time of transfer will remain in effect.

Opt-Outs

An Employee who Opts-Out of the South Dakota State Employee Health Plan can return to the Plan as a result of special enrollment or during any Annual Enrollment Period.

If the Employee and eligible Spouse and Dependents lose the other group Health Coverage during the Plan Year through no fault (involuntary loss of coverage), the Employee and eligible Spouse and Dependents may return to the South Dakota State Employee Health Plan and select either health plan.

The Bureau of Human Resources must be notified within 60 days following the date the participant loses other coverage. To re-enroll, a certificate of Creditable Coverage from the other group health plan showing the effective and ending dates of coverage under that Plan, as well as proof of loss of coverage must be provided. By law, employees must be allowed to return to the Plan if they lose group Health Coverage under another plan.

If the Employee does not notify BHR within this 60 day period, any Spouse and Dependents will not be eligible for coverage until Annual Enrollment with an effective date of July 1st.

DUAL COVERAGE UNDER THIS PLAN

No person may be covered under the Plan at the same time as an Employee, a Spouse or a Dependent or as a Dependent of more than one Employee. Either Spouse can carry Dependent coverage.

If a Spouse and Dependent have a break in coverage, a special enrollment event or a qualified family status change such as marriage, birth, or adoption must occur to allow the Spouse and Dependent to re-enroll in the South Dakota State Employee Health Plan. If there is not a special enrollment or family status change event, the Spouse and Dependent must enroll for coverage during Annual Enrollment. The effective date of coverage is July 1st.

FAMILY STATUS CHANGES

The coverage will begin on the payroll cycle nearest the 1st or the 15th of a month if the effective date is same as the date of the qualifying event.

The only time a coverage change can be made during a Plan Year is within 60 days of a Special Enrollment Period or within 60 days of a qualifying event. Coverage changes include adding or dropping a Spouse and Dependent from coverage or re-electing coverage for the Employee and/or his or her eligible Spouse and Dependents upon approval from the Bureau of Human Resources. Employees are allowed to make a change only once during the 60 days of a Special Enrollment Period or within 60 days of a qualifying event.

The coverage effective date will be contingent on receipt of all appropriate paperwork and required contributions nearest the 1st or 15th of the month.

Examples of qualified changes in family status include:

- Marriage;
- Divorce;
- Death; and
- Birth, adoption, or placement for adoption of a child.

In certain circumstances, the issuance of a Medical Support Order is also considered an acceptable Family Status Change. See “Words and Phrases” for the definition of “Medical Support Order”. Changes can also be made to Health Plan coverage during the Plan Year if eligible Spouse and Dependents are covered by another company’s health plan and the Employee wants to remove them from, or add them to, the State Plan because they acquired or lost coverage during the Spouse’s enrollment period. If the Bureau of Human Resources is notified later than 60 days, the Spouse and Dependent must enroll for coverage during Annual Enrollment. The effective date of coverage is July 1st.

SPECIAL ENROLLMENT PERIODS

If the Employee declines enrollment for himself/herself, Spouse or Dependents because of other health insurance coverage, the Employee, Spouse and Dependents will be able to enroll in this Plan if Family Status Change is received within 60 days, as a result of loss of coverage.

In addition, if an Employee has a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, Employee may enroll the Spouse or Dependents provided the Employee is covered under the Plan and Family Status Change is received within 60 days after the marriage, birth, adoption, or placement for adoption.

Involuntary losses of coverage are considered special enrollment situations if there is no more than a 63-day break in coverage, and include, but are not limited to, the following types of situations.

- The Employee is laid off;
- A company closes;
- An employer fails to pay timely contributions on behalf of the employee;
- Expiration of COBRA; or
- Enters a non-eligible status.

Some voluntary losses of coverage are portable and considered special enrollment situations. No waiting period applies:

- If there is no more than a 63-day break in coverage; and
- The applicant is able to provide proof of continuous Creditable Coverage from the time of initial eligibility with the South Dakota State Employee Health Plan to date of application for coverage.

Examples include, but are not limited to, the following types of situations:

- Quits;
- Retires;
- Enters a non-eligible status; or
- Is terminated.

Some examples of voluntary loss of coverage in which a waiting period is applied include, but are not limited to:

- The Employee failing to pay contributions for coverage in a timely manner; or
- Increase in cost of coverage with another plan.

CONTRIBUTION RATES (COST OF COVERAGE)

Employees will receive information about the cost for Health Coverage during annual enrollment or before enrolling as a new hire. To view Active Contribution Rates, visit:
<http://benefits.sd.gov/Files/2017/fy17decisionguide.pdf> .

If the Employee is a non-tobacco user, the State of South Dakota pays the full cost of Employee coverage.

If the Member or Spouse is a tobacco user, a tobacco user fee will be applied.

The Employee pays the cost of coverage for a Spouse and Dependents under the Health Plan. Spouse contribution rates are based on age of the Spouse.

The Plan Administrator reserves the right to adjust contribution rates during the Plan Year.

Employees and eligible Spouse and Dependents who elect continuation of coverage pay the cost for COBRA/Retiree contribution rates. To view Active Contribution Rates, visit <http://benefits.sd.gov/Files/2017/fy17decisionguide.pdf>. To view COBRA/Retiree Contribution Rates, visit <http://benefits.sd.gov/Ratesrc.aspx>.

MAJOR MEDICAL BENEFITS

The following provisions apply to the \$750 Deductible Plan and the \$1,800 Deductible Plan. Reference the Master Schedule of each plan for more information.

Within the provisions of Plan coverage, the Plan Administrator will pay the benefit, if any, for covered charges Incurred:

- (a) As result of Injury, disease, or Pregnancy; and
- (b) While the Employee is covered on the South Dakota State Employee Health Plan.

In any one Plan Year, the benefit will be equal to an amount determined by removing any applicable Deductible and Copayments (Member responsibility), and then multiplying the remainder by the applicable Coinsurance amounts that apply:

- (a) Covered Hospital charges Incurred by the Member;
- (b) Covered surgical charges Incurred by the Member; and
- (c) Covered medical charges Incurred by the Member.

The Plan Administrator will not pay more than the Benefit Maximum for all covered charges Incurred by the Member in his or her lifetime. (See "Master Schedule.")

Benefit Percentages, applicable Deductible and Copayments, Benefit Maximums, and Plan Year Maximums are shown in the Master Schedule.

MEDICAL OUT-OF-POCKET MAXIMUM

A medical Out-of-Pocket Maximum will apply in each Plan Year to any Member of the State Plan. The limit equals the maximum amount of covered charges that a Member is responsible for.

Amounts that apply to the medical Out-of-Pocket Maximum include:

- (a) The Deductible;
- (b) Benefit percentages (Coinsurance); and
- (c) Copayments.

When the Out-of-Pocket Maximum is reached during a Plan Year, the Plan will pay 100% for most covered charges thereafter Incurred in that Plan Year. Out-of-Pocket Maximums are shown in the Health Plan Comparison Chart.

The following do not apply to the medical Out-of-Pocket Maximums:

- (a) Charges above the contracted rate for DAKOTACARE, Sanford or other participating providers if the covered Member does not use approved facilities. Member is responsible for paying the charges above the contracted rate;

- (b) Charges above the Plan Maximum Allowable Charges (MAC) or Usual, Customary, and Reasonable (UCR) charges. Member is responsible for paying the charges above the MAC or UCR;
- (c) Charges for services not covered by the Plan;
- (d) Penalties for not obtaining a second opinion when required;
- (e) Penalties Incurred when Pre-authorization is not arranged when required; and
- (f) Prescription drug Copayments. Prescription drug Copayments for the \$750 Deductible Plan apply to separate \$1,000 per person or \$2,500 for family of three or more per Plan Year drug Out-of-Pocket maximum.

NOTE: The State reserves the right to incentivize participation to the choice of provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The Member may choose a provider, service, or supply other than one approved by the State, but the Member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The Member is responsible for all remaining charges. These remaining charges will not apply to the annual medical Out-of-Pocket Maximum.

OBTAINING HEALTH SERVICES

DAKOTACARE and Sanford providers will be the primary source of medical care for Members. If health services are received from non-DAKOTACARE and non-Sanford providers, benefits may be limited or reduced.

DAKOTACARE and Sanford providers may prescribe, order, or recommend the services of, or refer a Member to a non-DAKOTACARE or non-Sanford provider; however, this does not make such services eligible for reimbursement under the terms of this Plan. To be reimbursed, services must be covered by this Plan, must be provided while the Member is enrolled in the Plan, and must be Medically Necessary.

MEDICALLY NECESSARY TREATMENT

The State reserves the right to determine if a service or supply is Medically Necessary. Many services will be reviewed for appropriateness and medical necessity before the services are rendered, through the Pre-authorization process. Other services, such as emergency care and emergency transportations may be reviewed for appropriateness and medical necessity after treatment is provided.

Services that are not Medically Necessary will not be covered by the Plan.

Pre-authorization by HMP does not guarantee coverage under the Plan. The services must still fall within Plan provisions and the definition of covered services, and must not exceed Plan maximums. The Member receiving the service must also be eligible for coverage at the time the service is provided.

USUAL, CUSTOMARY, AND REASONABLE CHARGES (UCR) AND/OR MAXIMUM ALLOWABLE CHARGES (MAC)

UCR or MAC is the maximum amount that will be covered by the Plan for eligible charges.

DAKOTACARE and Sanford providers agree to accept these maximums as payment in full for those services. Generally, when a DAKOTACARE or Sanford provider is used, the Member is not responsible for paying charges in excess of UCR or MAC.

NOTE: The State reserves the right to incentivize participation to the choice of provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The Member may choose a provider, service, or supply other than one approved by the State, but the Member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The Member is responsible for all remaining charges. These remaining charges will not apply to the annual medical Out-of-Pocket Maximum.

COVERED CHARGES

Members shall be entitled to Medically Necessary services and supplies, if provided by or under the direction of a Physician. These services are subject to:

- 1) The limitations, exclusions, and other provisions of the Plan;
 - 2) Payment by the Member of any applicable Deductible, Copayment, and Coinsurance specified for any service; and
 - 3) Pre-authorization by HMP or DAKOTACARE, in certain instances.
- (a) Charges for the following services qualify as covered Hospital charges if the services are for a Hospital stay; days of inpatient care at an Extended Care Facility (ECF); or Acute Rehabilitation Facility. These services include:
- 1) Semiprivate room and board provided the daily charge is Medically Necessary; pre-authorized by HMP; and does not exceed the maximum covered room and board charge.. Private room rate only allowed if no semiprivate room is available.
 - 2) Other Medically Necessary services and supplies for the Member during the stay such as:
 - i. Durable medical equipment;
 - ii. Diagnostic and therapeutic services;
 - iii. Lab and x-rays;
 - iv. Speech, occupational, or physical therapy; or
 - v. Blood and blood plasma (administration of services and supplies covered when charged by the Hospital, ECF, or Acute Rehabilitation Facility-special nursing and Physician services not included).
 - 3) Medically Necessary covered medications prescribed and administered during an approved confinement. Care provided in an ECF or Acute Rehabilitation Facility must be ordered by a Physician and in place of a Hospital stay.
- (b) Covered surgical charges for surgery performed in a Hospital, physician office, clinic, or ambulatory surgical facility include:
- 1) Fees for a Surgical Procedure performed by a Physician, limited to UCR or the MAC for the service;
 - 2) Fees for an assistant surgeon (M.D., Physician Assistant, or the equivalent), if Medically Necessary. Such fees will be reimbursed per DAKOTACARE or Sanford fee schedule;
 - 3) Fees for anesthesia; and
 - 4) One Bariatric Surgery per person per lifetime on the Plan. The Member must meet certain criteria and be pre-authorized. See “Bariatric Surgery.”

- (c) Reasonable and Medically Necessary Charges arising from Approved Clinical Trials.
- (d) Applied Behavior Analysis for children up to age 19 with the following member's age limitations (benefit accumulation starts new on member's birthday):
 - 1) \$36,000 for Members up to age 6
 - 2) \$25,000 for Members up to age 14
 - 3) \$12,500 for Members up to age 19
- (e) Charges for the following services qualify as covered medical charges, but only if not already covered as Hospital or surgical charges:
 - 1) Medical treatment by a Physician;
 - 2) Physician consultation services when Incurred as a result of second surgical opinions or other requirements of the Plan Managed Care Program;
 - 3) Necessary ground or air ambulance service to the nearest facility equipped to treat the illness or Injury. Planned or scheduled transfers are subject to prior-authorization by Health Management Partners for Plan benefit consideration. Emergency ground and air ambulance services may be reviewed after treatment to determine appropriateness and medical necessity;
 - 4) Lab tests, x-rays, and other radiology exams;
 - 5) Anesthetics, oxygen, and the administration;
 - 6) Blood, blood plasma, and the administration of blood and blood plasma;
 - 7) Chemotherapy;
 - 8) Optometric services for the diagnosis or treatment of a medical condition or disease (e.g., glaucoma) or for an Injury to the eye. Immediately following surgery, coverage also includes eyeglasses or contact lenses required because of an eye Injury or cataract surgery;
 - 9) Hearing tests when prescribed by a Physician and Medically Necessary or for children up to nineteen years old. Hearing aids of medical necessity and fitting up to age eight. Cochlear implants are covered when Medically Necessary and approved by HMP;
 - 10) Dental services:
 - i) As needed due to an Injury to sound natural teeth unless, Injury to the teeth or their surrounding tissue or structure is caused by chewing. Services must begin within 12 months of the Injury;
 - ii) For surgical removal of impacted or partially impacted teeth;
 - iii) For removal of tumors or cysts;
 - iv) For drainage of an abscess or cyst; or
 - v) Covered under this health plan are considered primary to any other dental policy.
 - 11) Services and supplies provided for a jaw condition if needed due to an Injury, Medically Necessary surgery, or treatment of TMJ;

Medically Necessary treatment of TMJ is limited to a \$5,000 Benefit Maximum per person. The TMJ maximum includes diagnosis, treatment, appliances, and surgery needed to correct this condition of the jaw;
 - 12) Medically Necessary speech, occupational, or physical therapy is eligible with prior authorization, regardless of diagnosis. Therapy must be prescribed by a Physician, with treatment beginning within 30 days from the date of the Physician's prescription.

Therapy ordered by a physician that is received in addition to or above the *Birth to Three Program* or received in addition to or above therapy in the school systems is a covered benefit when it meets medical necessity. Speech therapy services meet the definition of medical necessity when performed to restore or improve speech in Members who have a swallowing or speech-language disorder.

Speech therapy is typically offered in school settings and in developmental learning centers. Speech therapy services do not meet the definition of medical necessity for conditions such as, but not limited to, the following:

- Psychosocial speech delay;
- Behavioral problems;
- Attention disorders;
- Learning disabilities;
- Developmental delay that is not the result of a specific genetic disorder; or
- Stammering, stuttering.

- 13) Infertility assistance includes up to a \$3,000 Benefit Maximum for diagnosis and medical treatment (excluding infertility drugs). The Health Plan does not cover charges for artificial insemination or in vitro fertilization;
- 14) Durable medical equipment (DME) eligible as rental are covered at the monthly rental rate up to the purchase price. DME must be obtained through a DAKOTACARE or Sanford participating provider to be considered eligible. Members obtaining DME through a non-DAKOTACARE or non-Sanford provider must obtain preauthorization through HMP.

Repairs or replacements of prostheses and other equipment must also be considered Medically Necessary for the condition, and be consistent with current equipment. See “Benefit Exclusions” for exceptions;

- 15) Charges for covered services provided at the South Dakota Human Services Center or performed by nurses of the South Dakota Department of Health acting within the scope of their license;
 - 16) Services provided by the South Dakota Department of Health Family Planning Clinics including contraceptive implants and removal, and Depo-Provera injections;
 - 17) Acupuncture performed by a qualified provider, such as a Physician or Chiropractor. The Plan does not cover services provided by an acupuncturist;
 - 18) Chelation therapy that is Medically Necessary and pre-authorized;
 - 19) Radioactive isotope therapy; and
 - 20) Radiotherapy.
- (f) Charges for the following qualify as covered home healthcare charges but only to the extent that the charges are pre-authorized as Medically Necessary and received during convalescence in the Member’s home:
- 1) Skilled nursing care provided or supervised by a registered nurse, affiliated with a licensed home healthcare agency;
 - 2) Home health aide services (mainly Patient care);
 - 3) Physician ordered physical, occupational, speech, and respiratory therapy;
 - 4) Medical social services by a licensed medical or psychiatric social worker who is supervised by a Physician;

- 5) Medical supplies and equipment; and
- 6) Medically Necessary private-duty skilled nursing when part of a written home healthcare treatment plan and provided by a nurse affiliated with a licensed home healthcare agency.

NOTE: See “Benefit Exclusions” for exceptions.

- (g) Hospice care provided in the home, or an approved facility that is pre-authorized. See “Benefit Exclusions” for exceptions.
- (h) The Plan covers charges for Reasonable and Medically Necessary transplant services that are approved by the Food and Drug Administration and are not Experimental/Investigational such as:
 - 1) Bone marrow and stem cell transplants for certain conditions;
 - 2) Cornea;
 - 3) Heart;
 - 4) Heart/lung;
 - 5) Kidney;
 - 6) Kidney/pancreas;
 - 7) Pancrease/liver
 - 8) Liver; or
 - 9) Lung.

Benefits are payable for both recipients and donors covered by the Plan. Covered charges Incurred during the transplant period include, but are not limited to:

- 1) Pre-transplant evaluation;
- 2) Organ procurement/listing fees, surgical, storage and transportation costs by the donor or Incurred and directly related to the donation of the organ used in an organ transplant procedure. Reasonable transportation costs to and from the site of transplant procedure are covered for the donor and a companion for the evaluation and procedure only. The Benefit Maximum for eligible donor services will not exceed \$50,000 per person;
- 3) Inpatient expenses and medication;
- 4) Professional fees;
- 5) Reasonable transportation costs (mileage reimbursement based on the IRS medical mileage) to and from the site of the transplant procedure are covered for the transplant recipient and a companion for the initial evaluation and procedure only;
- 6) Necessary and reasonable lodging for the transplant recipient and a companion Incurred during the transplant procedure based on U.S. General Services Administration allowables; and
- 7) Medically Necessary follow-up care.

NOTE: The transplant benefit period is defined as the period of time from the date the Member receives Pre-authorization and has an initial evaluation for the transplant procedure until one year after the date the procedure was performed. For maximum benefits, services must be pre-approved and provided by an approved facility as determined by the Plan.

The State reserves the right to incentivize participation to the choice of provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The Member may choose a provider, service, or supply other than one approved by the State, but the Member will be responsible for any cost differences. The Plan will only pay the amount they

would have paid for the approved provider, service, or supply. The Member is responsible for all remaining charges. These remaining charges will not apply to the annual medical Out-of-Pocket Maximum

- (i) Preventive Cancer Screening procedures.
- (j) Reconstructive Services.
 - 1) In compliance with the Women's Health and Cancer Rights Act, if a covered individual receives benefits in connection with a mastectomy, the South Dakota State Employee Health Plan covers reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas;
 - 2) Needed due to an accident; or
 - 3) Needed due to a birth defect when Medically Necessary.
- (k) Charges for chiropractic treatments, chiropractic massages via electronic modality, and chiropractic services.
- (l) The South Dakota State Employee Health Plan provides the following maternity health benefits for covered Members:
 - 1) Charges for prenatal care, delivery, and postpartum examinations. Blood tests and pap smears performed during the prenatal exam or postpartum checkup;
 - 2) Charges for services and Medically Necessary supplies associated with midwife deliveries, birthing centers, and home delivery, as long as a licensed medical professional or midwife is present;
 - 3) In compliance with the Newborns' and Mothers' Health Protection Act of 1996, the Plan provides a minimum of 48 hours of inpatient care for a mother and her newborn following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). Plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours); and
 - 4) One follow up home visit will be covered even if the mother and/or child are hospitalized for the entire 48 or 96 hours.

NOTE: Newborns of Dependents are not covered. See Benefit Exclusions.

- (m) Benefits are payable for diagnosis and inpatient and outpatient treatment for mental and nervous conditions by a DAKOTACARE or Sanford provider or Qualified Mental Health Professional (QMHP). Physicians licensed pursuant to SDCL 36-4 are considered Qualified Mental Health Professionals and are not required to receive the endorsement by the South Dakota Department of Human Services.

NOTE: The Health Plan will cover Biologically-Based Mental Illnesses in the same way as other covered illnesses. Biologically-Based Mental Illness means any mental illness which current medical research affirms is caused by a neurobiological disorder of the brain; which substantially

impairs perception, cognitive function, judgment, and emotional stability; and which limits the life activities of the person with the illness. The term includes schizophrenia, schizoaffective disorder, bipolar affective disorder, major depression, obsessive-compulsive disorder, and other anxiety disorders, which cause Significant Impairment of Function, and other disorders proven Biologically-Based Mental Illnesses. See “Words and Phrases.”

The Plan covers mental health treatment as follows:

- 1) Inpatient treatment for mental and nervous conditions requires Pre-authorization and are covered the same as any other Hospital stay;
- 2) Outpatient treatment of mental and nervous conditions are covered the same as any other covered illness; and
- 3) Residential Day treatments for mental and nervous conditions requires Pre-authorization and are covered the same as any other covered illness.

Covered services may include:

- 1) Evaluations and individual and group therapy (for the Member); or
 - 2) When Patient is present, family counseling in cases of depression and attention deficit disorder.
- (n) Benefits are payable for inpatient and outpatient treatment for alcohol and substance abuse by a DAKOTACARE or Sanford provider, Certified Chemical Dependency Counselor (CCDC), or Qualified Mental Health Professional (QMHP). Physicians licensed pursuant to SDCL 36-4 are considered Qualified Mental Health Professionals and are not required to receive the endorsement by the South Dakota Department of Human Services.

Pre-authorization is required for inpatient and residential day treatment of alcohol and substance abuse.

- (o) Cardiac self-management training and education. Pre-authorization is required.
- (p) Ossatron lithotripsy procedures (extracorporeal shock wave treatment for chronic Proximal Plantar Fasciitis). The Plan covers facility and Physician charges associated with this procedure. Benefits are limited to a \$5,000 Benefit Maximum per person.
- (q) HIV tests.
- (r) End Stage Renal Disease pharmaceuticals prescribed for Medicare recipients (not including age 65 and Retirees).
- (s) Screening for Sickle Cell disease in newborns.
- (t) Physician prescribed intravenous feeding following the diagnosis of Mucopolysaccharidosis type IVA.
- (u) Physician prescribed dietary management and formula for the treatment of phenylketonuria (PKU).
- (v) Amino Acid-Based Elemental Formulas for children age five and under for treatment of maldigestion or malabsorption.

Amino Acid-Based Elemental Formulas are not covered for all other conditions including milk allergy and the treatment of simple caloric deficits in Members with normally functioning gastrointestinal tracts.

The Amino Acid-Based Element Formulas must be prescribed in writing by a pediatrician, allergist, or gastroenterologist.

- (w) Diabetic supplies for insulin infusion pumps and diabetic monitors.
- (x) Maternity services include obstetrical care for a Pregnancy (e.g. including one Physician visit per month for weeks 0-28, two visits per month for weeks 29-36, and one visit per week for weeks 37 to delivery), delivery and postpartum care, lab charges and other ancillary services associated with Office Visits. Additional incentives for expectant mothers who enroll in Our Healthy Baby program.
- (y) Genetic testing will be covered when all of the following criteria have been met:
 - 1) The targeted treatment is a covered benefit of the healthcare plan;
 - 2) The individual is a candidate for the targeted treatment;
 - 3) The genetic testing results will directly impact the treatment plan and medical outcomes;
 - 4) The testing method is scientifically proven to be valid in detecting the specified gene and the relationship between the gene and treatment have been validated through randomized control trials; and
 - 5) Genetic testing resulting in a negative correlation with the targeted treatment may result in a denial of the targeted treatment.

NOTE: The State reserves the right to incentivize participants to the choice of provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The Member may choose a provider, service, or supply other than one approved by the State, but the Member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The Member is responsible for all remaining charges. These remaining charges will not apply to the annual medical Out-of-Pocket Maximum.

BENEFIT EXCLUSIONS

The Plan does not pay any benefits for the following services or supplies. Refer to “Covered Charges” for exceptions.

- (a) Incurred in connection with any services provided before the Member was covered by the Plan.
- (b) Not Medically Necessary, except for routine care of a newborn received during the Hospital stay which begins at birth.
- (c) Provided without a Physician prescription, recommendation, or approval. Charges, whether or not Reasonable or Medically Necessary, for which a third-party, including a third-party insurance company, is legally required to pay. See SUBROGATION AND REIMBURSEMENT
- (d) Charges arising for or in connection with Experimental/Investigational Treatment, unless Reasonable, Medically Necessary and part of an Approved Clinical Trial.
- (e) Excess costs above the Plan accepted maximums –UCR charges or MAC - when the Member receives services from a non-DAKOTACARE or non-Sanford provider.

- (f) The cost difference when a Member chooses a provider, service or supply that is not an approved provider, service or supply by the plan.
- (g) Provided in connection with Custodial Care.
- (h) Provided by or as a benefit under Medicare or any other Healthcare Plan.
- (i) Which would not have been billed if benefits were not available.
- (j) For which no one is legally required to pay.
- (k) For which the State of South Dakota cannot legally provide benefits.
- (l) An Injury or sickness, which arises out of or in the course of any employment for wage or profit and is paid by workers' compensation.
- (m) For any Injury, illness, or disability sustained while serving on full-time active duty in the armed forces of declared war or undeclared war, including resistance to armed aggression.
- (n) Injuries sustained while participating in a felony or a riot or while incarcerated because of a felony or riot.
- (o) Charges arising from or in connection with any attempt to defraud this Plan, including but not limited to an attempt to add a person to coverage who is not a Spouse or a Dependent.
- (p) Services rendered by the Employee, a Member of the Employee's family, or by any person who resides in the Employee's home. The Employee's family consists of the Employee, the Employee's Spouse, and children, brothers, sisters, and parents of either the Employee or the Employee's Spouse.
- (q) School, sports, travel or employment-related physicals.
- (r) Routine screenings for hepatitis except in the event of maternity.
- (s) Charges for food, food substitutes, food supplements including infant formulas, and vitamins that are purchased for consumption on an outpatient basis, whether prescribed or not except as indicated under "Covered Charges." Charges are allowed in the event of outpatient Hospice care when a feeding tube is required.
- (t) Drugs or supplies, or prescribed drugs/supplies, which are available over the counter except as, indicated under "Covered Charges or Preventive Medications."
- (u) Personal comfort or convenience items while Hospitalized including but not limited to TV usage and telephone usage.
- (v) Durable medical equipment prescribed solely for convenience or because it is the most recent model including but not limited to:
 - Sauna and whirlpool devices;
 - Items and supplies related to the use of Durable Medical Equipment (e.g., batteries, battery chargers, AC/DC adapter plugs, blood pressure cuffs, etc.);

- Wheelchair; and
 - Cochlear implant batteries.
- (w) Exercise equipment and club Membership even when prescribed or recommended by a Physician.
- (x) Whirlpool or aqua-massage therapy.
- (y) Any treatments or services that have no ability to cure medical conditions, but are used only to alleviate symptoms or behaviors (e.g., massage therapies) except as indicated under “Covered Charges.”
- (z) To reconstruct an external part of the body for cosmetic reasons or to correct a developmental defect except as indicated under “Covered Charges.”
- (aa) Enhancements designed to facilitate personal lifestyle choices (whether Medically Necessary or not), including services and supplies intended mainly to improve personal performance or appearance, provided primarily to beautify. See also Prescriptions Not Covered under Pharmacy.
- (bb) Weight control interventions such as surgery unless approved by HMP. Weight control medications unless approved by DAKOTACARE.
- (cc) Any eye care service or supply provided for diagnosis or treatment of astigmatism, myopia, hyperopia, or presbyopia, including eye examinations and surgery.
- (dd) Eyeglasses, contact lenses, and their fitting, except when needed immediately following surgery for an Injury to the eye or following cataract surgery.
- (ee) Audiology (hearing) tests except as indicated under “Covered Charges.”
- (ff) The fitting or cost of a hearing aid or earplugs except as indicated under “Covered Charges.”
- (gg) Dental treatment except as indicated under “Covered Charges.”
- This exclusion includes implants, gingivitis, orthodontic services, veneers, periodontal treatments and surgery, caps/crowns, prosthesis and removal, care or alignment of the teeth because of an Injury to the teeth (or their surrounding tissue or structure) caused by chewing.
- (hh) Charges in connection with a Dependent’s newborn.
- (ii) Routine foot care, except Medically Necessary custom fit orthotic devices.
- (jj) Transportation or lodging, except as provided under ambulance, required second surgical opinion or organ transplant benefits.
- (kk) Religious counseling and marital counseling.
- (ll) Treatment for compulsive gambling.
- (mm) Family group therapy (e.g., parent/child relationships) when the Patient is not present.

- (nn) The use of Continuous Positive Airway Pressure (CPAP) when used solely to control behavior problems or to resolve behavioral issues.
- (oo) Recreational or educational therapy and other forms of non-medical self-care, unless provided as part of Plan-approved Diabetic or Cardiac Education or rehabilitative care. This includes learning disability therapy and treatment normally provided through other mandated programs.
- (pp) Wigs needed for hair loss resulting from any medical condition.
- (qq) Artificial insemination, in vitro fertilization, or treatment or drugs to reverse a sterilization procedure.
- (rr) Treatment or drugs to terminate a Pregnancy unless the mother's health is in danger or the Pregnancy is due to rape.
- (ss) Treatment or drugs prescribed in connection with milieu or milieu therapy.
- (tt) Services or drugs related to gender transformations.
- (uu) Charges covered by automobile or homeowners insurance that provides medical coverage while the policy is in effect.
- (vv) Ergonomic or other home or worksite evaluations.
- (ww) Construction, remodeling, or the structural alteration of a residence, vehicle, or workplace to accommodate the access to, mobility in, or use of the residence.
- (xx) Charges for smoking cessation classes, unless offered or sponsored by the South Dakota State Employee Health Plan.
- (yy) Charges for missed medical appointments.
- (zz) The cost of a second procedure/surgery if it can be determined that the procedure must be redone and is necessary because Physician instructions were not followed. The Member is responsible for 100% of the cost of the second procedure, and the cost of the second procedure/surgery does not apply to the annual medical Out-of-Pocket Maximum.
- (aaa) The following charges do not qualify as covered home healthcare charges:
 - 1) Charges for services rendered by the Employee, a Member of the Employee's family, or by any person who resides in the Employee's home. The Employee's family consists of the Employee, the Employee's Spouse, and children, brothers, sisters, and parents of either the Employee or the Employee's Spouse; or
 - 2) Charges for Custodial Care.
- (bbb) Outpatient prescription drugs except as covered by CVS Caremark under the pharmacy component of the Health Plan.
- (ccc) Services, supplies, or medications related to or treatment in connection with sexual dysfunction or sexual inadequacy, whether organic or psychological in nature.

- (ddd) Costs incurred for additional treatment when Member self-discharges or discontinues medical treatment against medical advice.
- (eee) Services related to and required as a result of services that are not covered. Medical and hospital services that are related to and required that arose solely as a result of services that are not covered by the plan will not be paid. Some examples of these services are:
 - 1) Cosmetic surgery;
 - 2) Non-covered organ transplants; and
 - 3) Services related to follow-up care or complications that arose solely as a result of the treatment during a hospital stay in which a non-covered service is performed.

Exceptions:

When a Member is hospitalized for a non-covered service and requires services that are not related to the non-covered service, the unrelated services are covered. For example, if a beneficiary breaks a leg while he or she is in the hospital for a non-covered service, the services to treat the broken leg are covered since they are not related to the non-covered service.

When a Member is discharged from a hospital stay in which he or she receives non-covered services and subsequently requires services to treat a condition or complications that arose and are not related to the non-covered services, reasonable and necessary medical or hospital services may be covered.

TIER 1 SERVICES, FACILITIES, AND PROVIDERS

The State reserves the right to regulate the choice of contracted provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The Member may choose a provider, service, or supply other than one approved by the State, but the Member may be subject to additional cost. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The Member is responsible for all remaining charges. These additional amounts will not apply to the annual medical Out-of-Pocket Maximum.

TIER 1

Tier 1 is based on the service, facility and provider. ***To receive the highest level of benefit, you must have a Tier 1 service performed at an approved Tier 1 facility by an approved Tier 1 provider.***

Tier 1 facilities have a preferred relationship with State of South Dakota to provide high quality medical and surgical services at reduced costs in a contracted rate that includes fees for: provider, anesthesia, lab work, pathology, and x-ray services for Tier 1 services. The services a Member receives at the Tier 1 facility three days prior to a procedure and 30 days after the procedure are covered at a contracted rate. Tier 1 Bariatric services are covered at a contracted rate for a 365 day period. Rapid City Regional and Spearfish Regional Tier 1 rates apply to the facility bill only.

All Tier 1 services must be pre-authorized by HMP. HMP will advise Members where Tier 1 services are available if a Member is scheduled to have a Tier 1 service. All pre-authorization requirements must be satisfied, and the Member must receive confirmation of pre-authorization before having services performed in order to receive the Tier 1 contracted rate.

Only the specific services listed on the Tier 1 Coverage Chart are subject to Tier 1. The Tier 1 Coverage Chart is available at <http://benefits.sd.gov/tier1.aspx>.

NON-TIER 1

If you have a Tier 1 service at a Non-Tier 1 facility or by a Non-Tier 1 provider, you will have a higher Out-of-Pocket Maximum. The Out-of-Pocket Maximum is determined by which health plan you are currently enrolled in. These amounts are referenced in the Master Schedule for each page.

The In-Network deductible and 75% coinsurance will apply to Non-Tier 1 facilities and providers if services are received in the DAKOTACARE or Sanford Network.

Non-Tier 1 facilities do not accept the contracted rate that includes fees for the provider, anesthesia, lab work, pathology, and x-ray services. Services three days prior and 30 days after are not included in the rate (365 days for bariatric services) for Non-Tier 1. If a Member utilizes a Non Tier 1 facility or provider for a Tier 1 service the Member will be billed separately for these services, increasing the cost to the Member and the plan.

COVERAGE FOR TIER 1

COVERAGE FOR TIER 1*			
\$750 Deductible Plan		\$1,800 Deductible Plan with HSA	
Tier 1*	Non-Tier 1	Tier 1*	Non-Tier 1
<ul style="list-style-type: none"> • \$750 per person Deductible • 25% Coinsurance • \$3,600 Out-of-Pocket maximum • \$8,125 Out-of-Pocket maximum per family of three or more 	<ul style="list-style-type: none"> • \$750 per person Deductible • 25% Coinsurance • \$5,350 Out-of-Pocket maximum • \$10,200 Out-of-Pocket maximum per family of three or more 	<ul style="list-style-type: none"> • \$1,800 per person Deductible • \$3,600 family Deductible • 25% Coinsurance • \$3,600 Out-of-Pocket maximum single • \$8,125 Out-of-Pocket maximum per family of three or more 	<ul style="list-style-type: none"> • \$1,800 per person Deductible • \$3,600 family Deductible • 25% Coinsurance • \$5,350 Out-of-Pocket maximum single • \$10,200 Out-of-Pocket maximum per family of three or more

** To receive the highest level of benefit, you must have a Tier 1 service performed at an approved Tier 1 facility by an approved Tier 1 provider.*

Note: Non-Tier 1 facilities must be a DAKOTACARE or Sanford Network Provider otherwise, Out-of-network charges apply.

TIER 1 FACILITIES, SERVICES, AND PROVIDERS

TIER 1 FACILITIES AND SERVICES LISTED REQUIRE PRE-AUTHORIZATION BY HMP

PROVIDER NAME	PROVIDER	CITY	Tier 1 CARDIAC	Tier 1 ORTHOPEDIC	Tier 1 BARIATRIC	Tier 1 RENAL CARE	Tier 1 GASTROENTEROLOGY
AVERA DIALYSIS	MUST BE AN AVERA PROVIDER	BROOKINGS, SD				X	
AVERA GREGORY HOSPITAL DIALYSIS		GREGORY, SD				X	
AVERA MCKENNAN HOSPITAL & UNIVERSITY HEALTH CENTER		SIOUX FALLS, SD				X	
AVERA SACRED HEART		YANKTON, SD				X	
AVERA ST. MARY'S		PIERRE, SD		X		X	X
AVERA ST LUKE'S		ABERDEEN, SD				X	
AVERA QUEEN OF PEACE		MITCHELL, SD				X	
BLACK HILLS SURGICAL HOSPITAL	MUST BE A DAKOTACARE NETWORK PROVIDER	RAPID CITY, SD		X	X		X
RAPID CITY REGIONAL HOSPITAL	MUST BE A DAKOTACARE NETWORK PROVIDER	RAPID CITY, SD	X	X	X		X
SANFORD ABERDEEN MEDICAL CENTER	MUST BE A SANFORD PROVIDER	ABERDEEN, SD	X	X	X		
SANFORD HOSPITAL		SIOUX FALLS, SD	X	X	X		
SANFORD MEDICAL CENTER BISMARCK		BISMARCK, ND	X	X	X		
SANFORD MEDICAL CENTER FARGO		FARGO, ND	X	X	X		
SANFORD VERMILLION MEDICAL CENTER		VERMILLION, SD	X	X			
SIOUX FALLS SPECIALITY HOSPITAL	SFSH TIER 1 PROVIDERS INCLUDE: MARK MILONE, CHANDAR SINGARAM, DON WINGERT, DAVE STRAND, BRADLEY THAEMERT, SCOTT BAKER, MIKE PERSON, MICHAEL BAUER, DR. DAVID KNUDSON	SIOUX FALLS, SD					X
SPEARFISH REGIONAL HOSPITAL*	MUST BE A DAKOTACARE NETWORK PROVIDER	SPEARFISH, SD		X			X

* Spearfish Regional Hospital provides limited orthopedic Tier 1 services.

To view a complete listing visit of Tier 1 services, <http://benefits.sd.gov/tier1.aspx> and choose the Tier 1 coverage chart.

Revised 5.15.15

**** To receive the highest level of benefit, you must have a Tier 1 service performed at an approved Tier 1 facility by an approved tier 1 provider.***

OUT OF COUNTRY COVERAGE

Members traveling or residing out of the country receive the same level of benefits for eligible charges as Plan Members residing within the country. UCR limits apply to these charges. To ensure prompt payment of claims, provider bills, and other documentation must be translated into readable English and converted into American dollar amounts. Conversion to American dollars is calculated using exchange values from date the services were Incurred prior to submission.

MANAGED CARE PROGRAM

The State of South Dakota contracts with Health Management Partners (HMP) to provide managed care services and utilization review through a managed care program.

If the guidelines of the Managed Care Program are not followed, benefits payable under the Plan may be reduced or denied.

If this is found to be the case, the Plan Administrator or its designee, after appropriate investigation, may terminate plan coverage for those services or prescription medications. The Plan Administrator may require the Member to select a single participating Physician, participating Hospital, participating pharmacy, or other participating healthcare provider for individual management and coordination of all future health services.

NOTE: The State reserves the right to incentivize participation to the choice of provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The Member may choose a provider, service, or supply other than one approved by the State, but the Member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The Member is responsible for all remaining charges. These remaining charges will not apply to the annual medical Out-of-Pocket Maximum.

When non-DAKOTACARE, non-Sanford or out-of-state providers are used and charges are more than these accepted amounts, the Plan will not cover the amount above the UCR or MAC amount, even if the Out-of-Pocket Maximum is met. The Member is responsible for paying the excess charges.

PRE-AUTHORIZATION OR PRE-NOTIFICATION OF SERVICES-IN-STATE

The Member or Member representative must contact HMP before any non-emergency Hospital Admission and before receiving certain services to provide details of the proposed Hospital Admission, service, or treatment. The authorization should be made as soon as possible after the surgery or service has been prescribed or scheduled to allow HMP enough time to explore medical necessity and pricing alternatives. Approval of Plan benefits requires adequate timing for authorization and cooperation from the provider and/or the facility. Pre-authorization is required for certain prescriptions to be covered under the Prescription Drug Plan. To view the Pre-authorization listing visit <http://benefits.sd.gov/Files/2017/FY17preauth.pdf>.

In the case of an emergency admission, the authorization must be made within 48 hours, if possible, after such admission. Certain other services (such as emergency room services) may be authorized on a retroactive basis, after treatment is provided. Contact HMP will initiate the review process.

The time limits described above may be waived if it is shown that:

- (a) It was not reasonably possible to provide such notification within the time limit which applies; and
- (b) Notification was provided as soon as was reasonably possible.

Pre-authorization does not guarantee coverage under the Plan. The services must fall within the South Dakota State Employee Health Plan provisions and the definition of covered services, and must not exceed Plan maximums. The Member receiving the service must also be eligible for coverage at the time the service is provided.

DAKOTACARE and Sanford providers will initiate required Pre-authorization review processes for the Member.

If a Member visits a non-DAKOTACARE or non-Sanford provider, the Member or a Member representative must contact HMP for review and Pre-authorization of services.

PRE-AUTHORIZATION OF SERVICES OUT-OF-STATE

For all Health Plan options, Members who reside in or near South Dakota are required to obtain Pre-authorization for any health care received outside the state of South Dakota (e.g., Mayo Clinic and University of Colorado). Members who reside outside of South Dakota (and not in a border state) must seek services from a PHCS Provider.

The Member or the Member representative must call HMP before any non-emergency Hospital Admission and before receiving certain services to provide details of the proposed Hospital Admission, service, or treatment. This call should be made as soon as possible after the surgery or service has been prescribed or scheduled to allow HMP enough time to explore medical necessity and pricing alternatives. Approval of Plan benefits requires adequate timing for authorization and cooperation from the provider and/or the facility.

In the case of an emergency admission, authorization must be made within 48 hours, if possible, after such admission. Certain other services (such as emergency room services) may be authorized on a retroactive basis, after treatment is provided. A call to HMP will initiate the review process.

The time limits described above may be waived if it is shown that:

- (a) It was not reasonably possible to provide such notification within the time limit which applies; and
- (b) Notification was provided as soon as was reasonably possible.

Pre-authorization does not guarantee coverage under the Plan. The services must fall within the South Dakota State Employee Health Plan provisions and the definition of covered services, and must not exceed Plan maximums. The Member receiving the service must also be eligible for coverage at the time the service is provided.

If a Member visits a non-DAKOTACARE or non-Sanford provider, the Member or a Member representative must contact HMP for review and Pre-authorization of services.

FAILURE TO MEET PRE-AUTHORIZATION REQUIREMENTS

If a Managed Care Program notification requirement is not satisfied when a Member is admitted to a Hospital or receives certain medical services, the Plan Administrator may reduce or deny benefits in connection with the Hospital Admission or service.

If a Member elects to receive services even though the services have not been authorized, the Plan will not pay benefits for those services, or will provide benefits at a lower level, depending on whether the service is covered by the Plan.

For example, if HMP determines that a portion of a Hospital stay is not Medically Necessary or if any day is not authorized as appropriate for that condition or treatment, all charges for that day will not be considered a covered charge. No benefits will be paid for all charges for that day.

SERVICES REQUIRING PRE-AUTHORIZATION

The list of services needing preauthorization can be found at:

<https://benefits.sd.gov/Files/2017/FY17preauth.pdf>

SECOND OPINIONS

The South Dakota State Employee Health Plan covers Physician consultation services when Incurred as a result of voluntary second surgical opinions or other requirements of the Plan Managed Care Program.

Voluntary second opinions are subject to the same Deductible and Coinsurance provisions that apply for any other surgical or medical procedures under the Plan.

The Plan Administrator may require second opinions for certain covered services (such as non-emergency surgical procedures) when HMP has cause to believe there is an effective and equivalent alternative to the original medical/surgical opinion. If Member does not receive the required second opinion, the procedure will not be covered by the plan. Non-emergency surgical procedures may include, but are not limited to, gastric bypass, sinus surgery, or anterior/lateral disc fusion. Second opinions are also required for surgical procedures that must be redone due to the Member not following Physician instructions.

Services will be covered as follows when a second opinion is required:

- 1) The Plan will cover 100% of the required second opinion consultations, including Office Visits, pre-authorized tests, and mileage costs. In requiring a second opinion, the Plan Administrator will consider medical necessity, cost (e.g., procedures/services above \$25,000), location, diagnosis, and other related factors concerning the medical condition of the covered Member. If Pre-authorization review and/or the second opinion process indicate that a Medically Necessary procedure can be beneficially performed at an In-Network facility, payment will be limited to the contracted fee at that facility. If the Member chooses an Out-of-Network facility, benefit will be processed as Out-of-Network with the higher deductible, Coinsurance, and Out of Pocket Maximum. Any charges over Usual, Customary, and Reasonable will not apply to the annual medical Out-of-Pocket Maximum.
- 2) If it is determined during Pre-authorization review or the second opinion process that a procedure must be redone and is necessary because Physician instructions were not followed, the covered individual is responsible for 100% of the cost of the second procedure/surgery. The cost of this surgery does not apply to the annual medical Out-of-Pocket Maximum.

See “Services Requiring Pre-authorization” and “Services Requiring Second Opinions” for additional information about specific services.

SERVICES REQUIRING SECOND OPINIONS

The following services may require second opinions:

- Anterior / Lateral disc fusion;
- Gastric bypass surgery;
- Sinus surgery;
- Surgery that is redone because the Member didn’t follow physician orders; and

- As determined by HMP, Plan Medical Management vendor.

UTILIZATION REVIEW SERVICES

Inpatient Services

Once the Hospital admission has been reviewed, HMP will provide confirmation of the approval to the doctor, the Hospital, and/or the Claims Administrator. HMP will remain in contact with the facility throughout the Hospitalization to monitor Member progress, and may explore alternative treatment settings or the need for additional days in the Hospital.

Emergency Room Services

Emergency Room (ER) Services will be retrospectively reviewed for appropriate utilization. Members who utilize the emergency room will receive contact from HMP for follow up including review of discharge instructions. Members may be subject to a reduction of ER benefits for inappropriate usage. Continued inappropriate ER usage may result in a 50% reduction in benefits or charges not being covered by the health plan. Reduced benefits and non-covered amounts are the responsibility of the Member and not applicable to maximum out of pocket amounts.

MEDICAL CASE MANAGEMENT

Case Management

Case management is a collaborative process that provides Members with health management support through a variety of coordinated programs. It is offered as a confidential and free program to Members who are experiencing complex health issues or challenges in meeting their health care goals. HMP provides case management for South Dakota State Employee Health Plan Members.

HMP case managers provide Members with information and direction about health issues, Health Coverage, available community resources such as help with transportation, and much more. They can help make sure the Member is getting the best use of the covered services available to them.

Case Management is intended to support the Physician's plan of care. The case manager may contact the Member's Physician office to develop a rapport to support ongoing collaboration throughout the time the Member is in the program.

The dedicated case manager will:

- Support the member and family.
- Collaborate with the healthcare team to meet the member's needs.
- Provide education and offer community resources as needed.
- Assist in coordination of healthcare needs.
- Advocate for the member.
- Provide member-focused care planning and implementation.
- Assist the member in achieving their healthcare goals.

Health conditions, which may be referred to a case manager, include but are not limited to:

- Active treatment of cancers or transplants;
- Depression or chemical dependency;
- Chronic diseases or chronic pain;

- Multiple sclerosis;
- Catastrophic events such as traumatic injuries;
- Readmissions to Hospital;
- High cost indications; and
- Neonatal Intensive Care Unit (NICU) admissions.

BARIATRIC SURGERY

Bariatric surgery (Roux-en-y or Gastric Sleeve Surgery) will be covered under the health plan when the Member meets the eligibility criteria, complies with the management plan, and it is done at a certified location. Guidelines to determine eligibility for bariatric surgery are as follows:

- The Member has a Body Mass Index (BMI) of 40 or greater or Member has a BMI of 35 or greater with at least two clinically recognized and treated conditions (e.g. sleep apnea, , diabetes, high blood pressure, high cholesterol or triglycerides, diagnosed arthritis) or which significantly interferes with activities of daily living or a BMI of 40 or greater with one clinically treated condition, recognized condition or a BMI of 45 and no treated conditions necessary.
- The Member must have failed non-surgical weight loss through an approved program with or without pharmacotherapy.
- No specifically correctable cause for obesity (e.g., an endocrine disorder) has been identified.
- Member has achieved full adult stature as determined by Physician.

Member must agree to participate in the five -phase case management program as described below.

Phase I - Active participation in the HMP bariatric case management program to prepare for the lifestyle changes necessary for a successful weight loss surgery. This phase typically lasts 4-12 months.

Member must receive evaluation and treatment from a facility contracted for bariatric surgery, and accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program.

Phase II - Preparation and approval for surgery if bariatric surgeon and bariatric management team finds Member appropriate for weight loss surgery.

Phase III – Bariatric surgery (Roux-en-y or Gastric Sleeve Surgery) at an approved facility as noted above.

Phase IV - One year post surgery with active participation in the HMP bariatric case management program to include surgical and nutritional follow-ups with contracted facilities.

Members who continue active participation in a HMP bariatric case management program for 12 months after bariatric surgery and maintain a BMI of 30% or less than pre-Bariatric surgery for at least four months will be eligible for one skin reduction surgery with a board certified plastic surgeon.

Phase V- Member will receive annual follow up from the HMP case management program to address continued needs, if necessary.

To enroll in the program or for detailed information about the five-phase program, contact the Bariatric Management Program at HMP:

- Email: weightloss@hmpsd.com
- Call toll-free: 1.866.330.9886

PRESCRIPTION DRUG PLAN

The Plan Administrator will pay a portion of the cost of covered prescriptions. Maximum benefits are paid when prescriptions are filled through the CVS Caremark network pharmacies.

To view the Formulary List, visit <http://benefits.sd.gov/Forms.aspx> and select the document under the Pharmacy section.

All prescriptions are subject to the coverage guidelines and limitations as determined by the Plan.

Participating pharmacies submit claims and are reimbursed by the Plan for charges allowed under the Pharmacy Network contract. If the Member purchases a prescription at a nonparticipating pharmacy, or does not show a Member ID card to the pharmacist, the Member will be required to pay the full price for the prescription at the time of purchase and then submit a claim for reimbursement. Reimbursement is limited to the CVS Caremark contracted rates cost, minus the applicable Copayments and Deductible. The claim form can be found at <http://benefits.sd.gov/Forms.aspx> and select the document under the Pharmacy section.

All Specialty Medications must be filled through the State's Specialty Pharmacy Program. After a first time courtesy fill, there is no coverage for a specialty medication except through the Specialty Pharmacy Program.

PRESCRIPTION COVERAGE UNDER THE \$750 DEDUCTIBLE PLAN

PHARMACY DEDUCTIBLE PER MEMBER PER PLAN YEAR

A \$50 Deductible per Member per Plan year exists on prescription drug coverage for those enrolled in the \$750 Deductible Plan. Before pharmacy benefits are paid, each Member must satisfy the \$50 Deductible. Once the pharmacy Deductible is met, applicable Copayments under the Five-Tier Prescription Drug Plan will apply.

COPAYMENTS

When the \$50 Deductible is satisfied, Member is responsible for applicable Copayments for covered prescriptions. If the price is less than the defined Copayment, you will pay the lesser of the two amounts.

FIVE-TIER PRESCRIPTION DRUG PLAN

The State of South Dakota offers coverage for generic medications and formulary brand products. Non-formulary products are not covered. When enrolled in the \$750 Deductible Plan the State of South Dakota offers a Five-Tier Prescription Drug Plan with various levels of Copayment for each tier. The tiers are:

PHARMACY NETWORK PRESCRIPTION BENEFITS	
Tier	Up to 30 day supply
Tier 1-Generic	\$10
Tier 2-Brand Preferred	\$40
Tier 3-Brand Non-Preferred	\$60
Tier 4-Specialty Preferred	\$60
Tier 5-Specialty Non-Preferred	\$85

PHARMACY OUT-OF-POCKET MAXIMUMS

Under the pharmacy Plan, there is a separate Out-of-Pocket Maximum for prescriptions. Pharmacy Copayments or other prescription drug costs do not apply to the medical out-of-pocket Deductible or medical Out-of-Pocket Maximum.

The maximum annual cost per Plan Year for covered medications for those enrolled in the \$750 Deductible Plan:

- (a) \$1,000 per Member; and
- (b) \$2,500 per family of three or more. No one family Member is eligible to meet more than the per Member Out-of-Pocket Maximum each Plan Year. The family Out-of-Pocket Maximum is satisfied when at least three family Members have prescription drug expenses totaling the \$2,500 Out-of-Pocket Maximum. If a family has met the Out-of-Pocket Maximum for the year, a family Member does not have to pay the \$50 deductible.

The pharmacy Out-of-Pocket Maximum includes the \$50 Deductible per Plan year and pharmacy Copayments.

The pharmacy Out-of-Pocket Maximum does not include:

- (a) Ancillary charges (the difference in cost between brand and generic drugs when purchasing a brand name drug when a generic is available);
- (b) Excess amounts paid at nonparticipating pharmacies;
- (c) Charges which are not covered by the Plan; or
- (d) Penalties for not pre-authorizing when required.

PRESCRIPTION COVERAGE UNDER THE \$1,800 DEDUCTIBLE PLAN

Under the \$1,800 Deductible Plan, a single \$1,800 Deductible and \$3,600 family Deductible applies to both medical expenses and prescription drug expenses combined.

When enrolled in the \$1,800 Deductible, there is not a pharmacy Deductible, no tiered Copayments, and no pharmacy Out-of-Pocket Maximum. Member pays the Deductible and Coinsurance until they satisfy the Out-of-Pocket Maximums.

COVERED PRESCRIPTIONS UNDER THE \$750 AND \$1,800 DEDUCTIBLE PLANS

Generally, the following are covered benefits:

- (a) Coverage is limited to the Plan formulary;
- (b) Prescriptions prescribed by a licensed provider, that require a prescription, either by federal or state law;
- (c) DESI drugs (drugs in use prior to 1962 that have been permitted to remain on the market while evidence of their effectiveness is reviewed under the FDA's Drug Efficacy Study Implementation [DESI] program);

- (d) Compounded medications, submitted with a valid National Drug Code (NDC) for a legend medication;
- (e) Insulin and other diabetic supplies which are prescribed by a licensed provider;
 - a. On the \$750 Deductible Plan—If purchased at the same time, syringes and insulin are covered by the insulin copayment. If syringes are purchased separately from the insulin, they are covered under a separate copayment;
 - b. On the \$750 Deductible Plan—If purchased at the same time, lancets and diabetic test strips are covered by the diabetic test strips copayment. If lancets are purchased separately from the diabetic test strips, they are covered under a separate copayment;
- (f) Legend prenatal vitamins;
- (g) Legend pediatric fluoride vitamins;
- (h) Oral/topical Contraceptives, excluding emergency contraceptives;
- (i) Drugs that are self-administered; or
- (J) Fertility agents when Medically Necessary (up to the \$3,000 maximum pharmacy benefit) as determined by HMP.

PREVENTIVE MEDICATIONS

The Plan covers qualified preventive prescription and over-the-counter (OTC) products as listed in the table below. These medications will be covered at 100% when the Member meets the preventive care guidelines. All medications require a prescription from a provider and must meet the definition of qualified preventive care as defined under preventive medications.

ELIGIBLE PREVENTIVE MEDICATIONS

Preventive Service/Item	Requirements
Aspirin to prevent cardiovascular events	Men age 45 to 79 and Women age 55 to 79 where the benefit outweighs potential risk.
Breast cancer medications to reduce risk	Medications such as tamoxifen or raloxifene for women at increased risk for breast cancer.
Fluoride supplements	Children age 6 months to 5 years with a fluoride deficient water supply.
Folic acid supplements	Women through age 50 years.
Iron Supplements	Children age 6 to 12 months who are at risk for iron deficiency.
Smoking Cessation	Members may utilize the South Dakota Department of Health QuitLine resources for product coverage. Select Rx products covered by the Plan.
Vitamin D Supplement	Men and women 65 years of age or older at risk for falls.
Bowel Preparations for Preventive Colonoscopy	Men and women between 50 and 75 years of age. Limit 2 preparations per year under preventive benefit.
Women's Services/Contraception	Contraceptive methods approved by the Food and Drug Administration (FDA) covered for women through age 50 years. Generic and select brand name medications included.

Prescription medications listed above will be processed through the pharmacy benefit. Over the counter medications may be submitted for preventive service coverage using the medical claim form found at <http://benefits.sd.gov/Forms.aspx> and choosing Preventive Medications under claim form.

The claim form along with the provider prescription and a receipt for the product must be submitted in order to be reimbursed.

GENERIC POLICY

If a generic drug is available, and a Member chooses to take the brand product, the Member will be responsible for the ancillary charge. The ancillary charge is the difference in cost between brand and generic drugs when purchasing a brand name drug when a generic is available.

PRESCRIPTION DRUG PLAN EXCLUSIONS

The following are excluded from coverage unless specifically listed as a benefit under “Covered Drugs”:

- (a) Charges for which a third-party, including a third-party insurance company, may be responsible;
- (b) Non-formulary medications;
- (c) Non-legend drugs, including any OTC medications;
- (d) Blood glucose monitors, diabetic swabs, and calibration solutions;
- (e) Emergency contraceptives;
- (f) Injectable medications which are not considered self-injectable;
- (g) All vitamins, except as noted under “Covered Drugs”;
- (h) All Durable Medical Equipment (DME);
- (i) Prescriptions used for cosmetic purposes;
- (j) Drugs labeled “Caution-limited by Federal law to investigational use,” or experimental medications that do not have NDC numbers even though a charge is made to the Member;
- (k) Charges for prescription drugs that exceed the CVS Caremark contracted rate;
- (l) Medication which is to be taken by or administered to a Member, in whole or in part, while a Patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
NOTE: Benefits for covered medications administered during an approved inpatient confinement are payable under the South Dakota State Employee Health Plan;
- (m) Charges for the administration or injection of any drug. Within the provisions of Plan coverage, these drugs, services, or supplies may be covered under the South Dakota State Employee Health Plan;
- (n) Drugs used for indications not approved by the FDA;
- (o) Legend drugs with OTC equivalents;
- (p) Homeopathic or nutritional supplements (or combination of these with legend drugs);
- (q) Prescription medications obtained by illegal means;

- (r) Replacement of supplies or medications that are lost, damaged, stolen, or used inappropriately including medications determined to be abused or otherwise misused;
- (s) Laetrile use in any form;
- (t) Allergy Serum is covered under the health plan. The claim should be submitted to DAKOTACARE as a medical claim and Member will be responsible for a medical copayment; and
- (u) Medications as identified on the Listing of Prescriptions Not Covered Under Pharmacy. To view the list of excluded medications visit <http://benefits.sd.gov/Forms.aspx> and select Pharmacy Listing of Prescriptions Not Covered Under Pharmacy.

EARLY REFILL POLICY

A minimum of 75% of the medication must be used before a refill will be allowed. In a special circumstance of a Member needing to refill the medication before leaving on vacation, the Member may have one prescription refilled early per Plan Year.

In these situations, the Member should contact the Benefits Program at 605.773.3148 or 877.573.7347 for pre-authorization.

DRUGS REQUIRING PRE-AUTHORIZATION

Certain medications require pre-authorization. For the current Pre-authorization list and who does the pre-authorization, visit <http://benefits.sd.gov/Forms.aspx> and choose Pre-authorization Listing. The Pre-authorization list is updated throughout the year.

STEP THERAPY PROGRAMS

Step therapy programs are implemented on certain therapeutic classes of drugs. The programs are designed to have Members begin with the most cost-effective and safest drug available (known as first-line drug therapy). The step therapy program will allow for more costly and higher-risk drug therapies if a Member fails the first-line drug therapy prescribed. The goal of these programs is to control costs and minimize side effects (from medications) that a Member may experience. The Step Therapy list is updated throughout the year. To view the list of current step therapy programs, visit <http://benefits.sd.gov/Forms.aspx> and choose Pre-authorization Listing.

HOME DELIVERY PRESCRIPTION PROGRAM

Members may use the CVS Caremark Home Delivery Prescription Program when they need to fill or refill up to a 90-day supply of certain maintenance drugs. The same Copayments apply to mail-order pharmacy as the retail pharmacy.

SUBMITTING CLAIMS

If a Member visits a nonparticipating pharmacy, or does not present a Member ID card, the Member must submit a claim for reimbursement to the pharmacy network's Claims Administrator. The claim must be submitted within one year from the end of the Plan Year in which the medication was purchased.

Reimbursement is limited to the State cost had the Member used a participating pharmacy, minus the applicable Copayments.

NOTE: Prescription drugs administered in a Physician's office (e.g., an injection of an allergy serum) also require the Member to file a claim for reimbursement. The Member should pay the provider when receiving this service.

PREVENTIVE CARE

ELIGIBLE PREVENTIVE CARE

The Plan covers:

- Well Child Care
- Annual Wellness Exam
 - Women—a Well Woman preventive visit or gynecological exam visit in addition to the Annual Wellness Exam
- Cancer Screening Procedures
- Pregnancy Care Preventive Screenings
- Scheduled Immunizations and Vaccinations
- Review prescription section for additional preventive care items

Covered “Eligible Preventive Care” also includes preventative care identified by the Department of Health and Human Services under the PPACA. Eligible Preventive Care is covered at 100% when the Member meets age and frequency requirements. The Preventive benefit can be applied to eligible service regardless of diagnosis on claim. Both health plans cover eligible preventive care according to the following schedules. To be covered by the plan, Preventive Care services, including immunizations, must be received from a participating provider.

When a covered Dependent attends school out-of-state, or when the Member resides out-of-state, Preventive Care services as listed are covered by the plan if Member visits a PHCS provider. If Member utilizes a non PHCS provider, any charges above UCR are the Member’s responsibility to pay.

ELIGIBLE PREVENTIVE OFFICE VISIT SCHEDULE

Age	Frequency
Birth to age 3 years*	<ul style="list-style-type: none"> • 3 to 5 days old • 1 exam between birth and 2 months • 1 exam at 2 months • 1 exam at 4 months • 1 exam at 6 months • 1 exam at 9 months • 1 exam at 12 months • 1 exam at 15 months • 1 exam at 18 months • 1 exam at 24 months • 1 exam at 30 months • 1 exam at 3 years See chart for specific services covered at exams.
4 -17 years**	1 exam per Plan Year See chart for specific services covered at exams.
18 years and up***	1 exam per Plan Year See chart for specific services covered at exams.
Pregnancy Preventive Screenings	See chart for specific services covered at exams.
Females under age 65– Well Woman or gynecological Exam	1 exam per Plan Year <ul style="list-style-type: none"> • Office Visit • Pap Smear • Breast Exam by Physician See chart for specific services covered at exam. This is in addition to Annual Wellness Exam. Pap smear is not required for this visit to be eligible.

***WELL CHILD CARE: Birth to 3 years**

Well Child Care Exam: Coverage provided for inpatient newborns; visits at 3 to 5 days old; and at or around 2, 4, 6, 9, 12, 15, 18, 24, 30 months, and 3 years.

Exams include: Health advice and information about development, behavior, safety/injury prevention, sleep positions, feeding, diet, daily care, physical activity and dental care. During the visit, the child may receive immunizations and screenings based on the healthcare practitioner's recommendations. Immunization chart included in this document includes recommendations at time of publishing.

Age	Frequency
Weight, Height/Length, Blood Pressure and Head Circumference	At every visit as part of well child exam. Head circumference up to age 24 months.
Developmental Screening/Surveillance	At every visit as part of well child exam.
	In-office screening with a standardized validated tool at 18 and 24 months. Maximum of two covered under well child care.
Vision	In-office medical screening as part of well child exam to detect amblyopia, strabismus, and defects in visual acuity. This is NOT a separate vision exam.
Hearing	In-office medical assessment as part of a well child exam. This is NOT a separate hearing exam.
Dental	Includes regular oral health screenings and referral to a dentist at the appropriate age. Healthcare practitioner may prescribe fluoride, if necessary, for a child over 6 months of age whose primary water source is deficient in fluoride. This is NOT a separate dental exam. See Pharmacy section for medication preventive coverage details
Hemoglobin or Hematocrit (Hgh/Hct)	One Hemoglobin or one Hematocrit between 9 and 15 months.
Lead Screening	One screening test at 12 months and one at 24 months.
Tuberculosis	Eligible as needed if screening questions are positive.

****WELL CHILD CARE: AGES 4 TO 17**

Well Child Care Exam: Once per plan year for children ages 4 to 17.

Exams include: Age and gender-appropriate health advice and information about dental care, exercise and physical activity, diet and nutrition, counseling for obesity (age 6 and over only), sun exposure and safety/injury prevention. When appropriate, alcohol, sexual behavior/sexually transmitted diseases (STDs), tobacco use and suicide prevention are also addressed. During the visit, the child may receive immunizations and screenings based on the healthcare practitioner's recommendation. Immunization chart included in this document includes recommendations at time of publishing.

** Age 4-17 Childhood Healthcare reform guidelines at time of publishing are as follows:

Guideline Title	Frequency
Height/Weight/BMI/Blood Pressure	At every well child care exam. A review of Body Mass Index (BMI) may be completed by the healthcare practitioner to screen for obesity at age 6 and older.
Vision	In-office medical screening as part of well child care exam to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5. This is NOT a separate vision exam.
Hearing	In-office medical assessment as part of well child exam. This is NOT a separate hearing exam.
Dental	This includes regular oral health screenings and referral to a dentist at the appropriate age. Healthcare practitioner may prescribe fluoride, if necessary, for a child whose primary water source is deficient in fluoride. This is NOT a separate dental exam. See Pharmacy section for medication preventive coverage details
Sexually Transmitted Infections	All sexually active adolescents should be counseled and screened for STIs, including Chlamydia, gonorrhea, syphilis and HIV.
Cervical Dysplasia Screening	Annual pap smear for females at high risk at the discretion of the healthcare practitioner.
Tuberculosis	As needed if screening questions are positive.
Depression	Starting at age 12 for major depression when systems are in place to ensure accurate diagnosis, psychotherapy and follow-up.
Hemoglobin or Hematocrit Screening for anemia	Annually

*****ANNUAL WELLNESS EXAM: 18 YEARS AND UP**

Annual Wellness Exam: Once per plan year for adults 18 years and up. Additionally, women are allowed a Well Woman or a gynecological exam annually while they are under 65.

Exams include: Health advice and counseling about dental care, exercise and physical activity, diet and nutrition, obesity, sun exposure, safety/injury prevention, domestic and interpersonal violence, alcohol, sexual behavior/sexually transmitted diseases (STDs) and tobacco use. During the visit a Member may receive immunizations and screenings based on the healthcare practitioner's recommendation. Immunization chart included in this document includes recommendations at time of publishing.

ANNUAL WELLNESS EXAM MEN AND WOMEN

Guideline Title	Frequency
Height/Weight/Blood Pressure	At every Wellness Exam.
Cholesterol Test	<u>Men & Women</u> : One per plan year.
Counseling for Healthy Diet	In-office assessment and counseling for individuals with hyperlipidemia and other known risk factors for cardiovascular disease and diet-related chronic disease.
Diabetes	Screen for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80.
Colorectal	Ages 50 and older: –One fecal occult blood test per plan year. –Colonoscopy every 10 years or flexible sigmoidoscopy every 5 years. –1 Colonoscopy every 3 Plan Years beginning at age 50 for Members requiring more frequent follow up due to personal history /previous findings on a colonoscopy. See Pharmacy section for medication preventive coverage details.
Sexually Transmitted Infections	High-intensity behavioral counseling to prevent STIs. All adults at risk screened for STIs including chlamydia (women), gonorrhea (women), syphilis and HIV.
Depression	Screen for major depression when systems are in place to ensure accurate diagnosis, effective treatment and follow-up.

For Women Only

Guideline Title	Frequency
Breast Cancer - Mammograms	One baseline screening mammogram between ages 35 to 39 for women. One screening mammogram per plan year beginning at age 40.
BRCA	Women with a family history (breast or ovarian cancer) associated with increased risk for harmful mutations in BRCA1 or BRCA2 should be referred for genetic counseling and BRCA testing if appropriate. (Limit: One per lifetime – Preauthorization Required)
Counseling Women at High Risk for Breast Cancer	Counseling for chemoprevention of breast cancer as part of Annual Wellness Exam or Well Woman Exam.
Breast Cancer Risk-Reducing Medications	For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene. See Pharmacy section for medication preventive coverage details
Cervical Cancer – Pap Smear	One screening pap smear per plan year.
HPV DNA Testing	High risk HPV DNA testing every three plan years for women with normal cytology results who are 30 or older.
Contraception	Prescription medications and devices that are approved by the Food and Drug Administration for treatment of and specifically prescribed for, contraception are available at zero-cost share to Member. Note: Zero-cost share is not available for brand medications impacted by the “generics policy” (see PRESCRIPTION DRUG PLAN for generics policy). See Pharmacy section for medication preventive coverage details.
Sterilization Procedures	Food and drug administration-approved sterilization procedures, patient education and counseling. Preauthorization Required for sterilization procedures
Osteoporosis Screening	One per lifetime for women age 60 and older.

For Men Only

Guideline Title	Frequency
Prostate Specific Antigen (PSA)	An annual diagnostic exam, including a digital rectal examination and PSA test for asymptomatic men age 50 and older

PREGNANCY CARE PREVENTIVE SCREENINGS

The following are per pregnancy and are expected to be encompassed in the Pregnancy Preventive Health Visit. Only one office visit is covered at 100%. If screenings occur at another visit, only the screening will be covered at 100%. Pregnant Members are encouraged to join the Our Healthy Baby Program as there are additional benefits available through the program.

Guideline Title	Frequency
Interventions to Support Breast-feeding	Interventions during pregnancy and after birth to promote and support breastfeeding.
Counseling for Tobacco Use	One screening per pregnancy for tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.
Screening for Anemia	One routine screening for iron deficiency anemia in asymptomatic pregnant women.
Screening for Bacteriuria	One screening per pregnancy for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
Screening for Chlamydial Infection	One screening per pregnancy for chlamydial infection for all pregnant women ages 24 and younger and for older pregnant women who are at increased risk.
Screening for Hepatitis B	Screen for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.
Screening for Rh incompatibility	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care and repeat between 24-28 weeks gestation unless the biological father is known to be Rh (D) - negative.
Screening for Syphilis	One screening per pregnancy for syphilis infection.
Screening for Gonorrhea	One screening per pregnancy for gonorrhea infection, if at high risk for infection.
Screening for HIV	One HIV screening per pregnancy.
Alcohol Screening	One screening per pregnancy for alcohol use and provide augmented pregnancy-tailored counseling to those who consume alcohol.
OB Panel	OB Blood Panel
Gestational Diabetes Screening	Women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
Breast-feeding	<p>Comprehensive support and counseling from trained providers, as well as access to non-disposable breastfeeding supplies, for pregnant and nursing women.</p> <p>Members will be reimbursed up to \$150 for a manual breast pump and up to \$220 for an electric breast pump.</p> <p>Limited to one manual pump every 12 months OR one electric pump every 3 plan years. Replacement pumps are covered for subsequent pregnancies for Members who have not received a pump within the timeframes outlined above.</p>

OUR HEALTHY BABY PROGRAM

The Our Healthy Baby™ Program is a voluntary HMP program available to expectant mothers covered by the South Dakota State Employee Health Plan.

The purpose of the HMP program is to provide support to expectant parents through individual case management, educational materials, and contact throughout the Pregnancy. By providing this service, HMP and the South Dakota State Employee Health Plan achieve healthier outcomes for Members.

Program incentives include:

- Expectant mothers covered under the Plan who enroll in the program within the first three months of Pregnancy receive a **\$250 non-tax incentive** into a Health Reimbursement Account if on the \$750 Plan or a Combination Health Reimbursement Account if on the \$1,800 Plan;
- Choice of one available prenatal or parenting book upon enrollment;
- One first trimester ultrasound to confirm viable pregnancy covered at 100% (Pre-authorized by HMP);
- One second trimester ultrasound to verify dates and growth covered at 100% (Pre-authorized by HMP);
- Online access to Pregnancy related information;
- Educational materials mailed to Members throughout the Pregnancy;
- Expectant mothers covered under the Plan who complete the program receive an additional **\$250 non-tax incentive** into a Health Reimbursement Account if on the \$750 Plan or a Combination Health Reimbursement Account if on the \$1,800 Plan upon successful participation and completion of program; and
- Follow-up after the Pregnancy.

Enrollment in the Our Healthy Baby™ Program does not automatically add the new child to the Health Plan.

To be covered, the child must be enrolled in the Plan within 60 days following the date of the birth. The Employee must complete a Family Status Change form during the 60 day time period and pay required contributions for coverage to take effect. The child of a Dependent cannot be added to the health plan.

If the child is not added during the 60-day Special Enrollment Period, the child will not be covered under the Plan. The Employee will be able to enroll the child during Annual Enrollment or when incurring qualifying family status change or after satisfying a waiting period. See “Special Enrollment” to the South Dakota State Employee Health Plan” sections.

For more information contact HMP at 888.330.9886.

SCHEDULED IMMUNIZATIONS AND VACCINATIONS

Scheduled immunizations and vaccinations are available under both health plans, covered at 100%, when incurred with a participating network provider.

When a covered Dependent attends school out-of-state, or when the Member resides out-of-state, Immunizations and Vaccinations as listed below are covered if Member visits a PHCS provider. If Member utilizes a non PHCS provider, any charges above UCR are the Member's responsibility to pay.

The following immunizations are covered at 100% when services are provided by a participating provider.

Treatment	Frequency
Hepatitis A Vaccine	At 12-23 months
Hepatitis B Vaccine	At birth, plus 2 between birth and 18 months
Rotavirus	At 2, 4, and 6 months
DTaP Vaccine	At 2, 4, 6, and 15-18 months
DTaP Booster	Once between 4 and 6 years
IPV Vaccine	At 2, 4, and 6-18 months
IPV Booster	Once between 4 and 6 years
MMR Vaccine	At 12-15 months and 2nd dose 4-6 years
HIB Vaccine	At 2, 4, and 6 months plus 1 booster at 12-15 months
Varicella Vaccine	At 12-15 months and 1 dose between 4 and 6 years; 2 doses for adults 19-65 years
Pneumococcal Conjugate Vaccine (PCV or Prevnar) a vaccine to prevent pneumonia	At 2, 4, 6, and 12-15 months
Pneumovax	Allowed with documented risk factors for ages 19 to 65 years, all adults 65 and older
Tdap	Once at 11-12 years of age, and every 10 years for adults
Tetanus/Diphtheria Booster	Every 10 years for adults
HPV	11-26 years, 3 dose series
Meningitis, Meningococcal Conjugate Vaccine	Age 11-12, and 1 booster at age 16.
Influenza Vaccine	<p>1 to 2 doses between age 6 months through age 6 and once each Plan Year thereafter.</p> <p>The State offers all covered Members flu shots at State sponsored clinics each year, beginning in October. Refer to http://benefits.sd.gov for times and locations.</p> <p>The plan will only pay for the cost of the vaccine and the administration fee for Members who choose to receive influenza vaccine somewhere other than a State sponsored clinic.</p> <p>Vaccines received at the pharmacy must be CVS Caremark participating pharmacy, and submitted through the pharmacy program.</p> <p>Vaccines received at a medical provider, must be received at a participating provider.</p>
Zoster (Shingle)	1 dose for adults age 60 and older
<p>Sources: Department of Health and Human Services, Center for Disease Control and Prevention, and South Dakota Department of Health.</p> <ul style="list-style-type: none"> • If a combination vaccine is received, the Member must be eligible to receive at least one of the vaccines included in the combination vaccine to be covered. • Vaccinations required for employment and travel are not eligible. 	

WHEN COVERAGE ENDS AND CONTINUATION OF COVERAGE

An Employee's coverage under the Health Plan ends on the earliest of:

- (a) Last day of the coverage period following the date employment ends, as set forth in (b) below;
- (b) Date the Employee ceases to be a Member of the class or classes eligible for such coverage;
- (c) End of the period covered by the Employee's last contribution for that coverage;
- (d) Last day of the coverage period following the date the Employee begins active duty in the armed forces; or
- (e) Date the Plan terminates.

Spouse and Dependent coverage ends on the earliest of these dates:

- (a) Date the Employee's coverage under the Plan ends;
- (b) Last day of the coverage period in which the Spouse or Dependent ceases to qualify as a Spouse or Dependent;
- (c) End of the period covered by the Employee's last contribution for that coverage;
- (d) Last day of the coverage period following the date the Spouse or Dependent begins active duty in the armed forces of any state;
- (e) Date the Employee becomes ineligible to have a Spouse or Dependents covered under that Plan; or
- (f) Date the Plan terminates.

Employment for coverage purposes ends on the date the Employee ceases active work or benefit eligible status changes with the Employer. The ending date of Health Coverage will be based on the pay period for which the Employee receives his or her final paycheck. Employees should contact their Human Resource/Personnel Office for specific information. In some circumstances, the participating Employee may elect COBRA coverage.

APPROVED LEAVE OF ABSENCE WITHOUT PAY

An approved leave of absence without pay is not treated as a termination of employment. An approved leave of absence without pay includes an absence due to Injury, disease, Pregnancy, or an absence pursuant to the FMLA of 1993 or the USERRA. Benefits under the South Dakota State Employee Health Plan may continue provided the Employee continues to make after-tax contributions to the Plan according to the billing process established by the Bureau of Human Resources or the Board of Regents. If Employee terminates employment, then coverage will end prior to the actual termination date and Retiree and COBRA continuation of coverage will not be available.

Spouse or Dependent health coverage during a period of absence will end if the Employee does not pay the required Spouse or Dependent contributions. For example, if the Employee goes on leave of absence without pay from January 1 until March 1, and does not pay the Spouse or Dependent contributions for coverage, the Spouse or Dependent will have a break in coverage. Coverage will also end if the authorized period of absence ends and the Employee does not return to work, or when the Plan Administrator otherwise determines that employment has terminated. Retiree and COBRA continuation of coverage will not apply.

If leave without pay contributions are not paid and the Employee terminates employment, then coverage will end prior to the actual termination date and Retiree and COBRA continuation of coverage will not be available.

RETIREE COVERAGE

Eligible retired Members may continue group Health Coverage as a Retiree Member up to the first day of the month in which they reach age 65, at which time coverage may be converted to the State-sponsored Medicare Supplement Plan. Election of COBRA will forfeit the right to retiree coverage. If a Member selects a lump sum retirement benefit payout, they forfeit their right to retiree coverage.

Eligible Members who are receiving a Disability benefit from the South Dakota Retirement System (SDRS), or who have been designated as disabled by the Social Security Administration, may continue COBRA coverage for up to 29 months. There is no COBRA continuation of coverage if the Member is a Medicare recipient.

Covered Spouse and Dependents can remain on the Plan for as long as they remain a qualified Spouse or Dependents.

Retiree Members pay 100% of the cost of their coverage for themselves, Spouses, and eligible Dependents.

OPTION TO CONTINUE COVERAGE (COBRA)

An Employee and the Employee's eligible Spouse and Dependents covered by the South Dakota State Employee Health Plan have the right to elect continuation coverage if coverage is lost because of one of the following qualifying events:

QUALIFYING EVENT		LENGTH OF CONTINUATION COVERAGE
1)	Employee's Termination (for reasons other than gross misconduct)	Coverage for former Employee and eligible Spouse and Dependents may be extended up to 18 months; up to 29 months if the Employee or an eligible Spouse or Dependent is disabled prior to or within 60 days following the date of the qualifying event.
2)	Employee's Death	Coverage may be extended up to 36 months for eligible Spouse and Dependents.
3)	Reduction of Employee's Hours	Coverage for the Employee and eligible Spouse and Dependents may be extended up to 18 months; up to 29 months if the Employee or the eligible Spouse or Dependent is disabled prior to or within 60 days following the date of the event.
4)	Divorce or Legal Separation	Coverage may be extended up to 36 months for qualified beneficiaries.
5)	Employee's Entitlement to Medicare	If an Employee becomes entitled to Medicare while an active Employee and within 18 months of that entitlement experiences a layoff, a termination of employment, or a qualifying reduction of his or her hours, qualified beneficiaries may extend coverage up to 36 months from the date the Employee became entitled to Medicare.
6)	Child Ineligible to be Covered as a Dependent	Coverage may be extended up to 36 months for the eligible Dependent.

The Employee or a family Member has the responsibility to notify the Employee's Human Resource Office of a divorce, legal separation, Medicare entitlement or enrollment, or a child losing Dependent status under the South Dakota State Employee Health Plan. This notification must occur within 60 days following the date of the event or the date on which coverage would be lost due to the event, whichever is later.

ELECTING CONTINUATION COVERAGE (COBRA)

For purposes of this Section, a qualified individual/beneficiary includes the Employee and any eligible Spouse and Dependent of the Employee who is covered by the Plan on the date of the qualifying event. An Employee, Spouse, and Dependents of an Employee who opts out of coverage under this Plan are not eligible for and may not elect continuation coverage pursuant to this section of the Plan.

The Employer is responsible for notifying the Employee and/or eligible Spouse and Dependents of the right to elect continuation coverage in the case of the Employee's death, termination of employment, or reduction in hours of employment. The Employee and/or eligible Spouse and Dependent have 60 days from the date coverage would end to elect continuation coverage. If the Employee and/or eligible Spouse and Dependent do not elect continuation coverage, group Health Coverage under the Plan will cease.

If the Employee, eligible Spouse, or Dependent elects continuation coverage, the Employee, Spouse, or Dependent may elect a plan with less coverage (e.g. When an active Employee, the Plan choice was the \$750 Deductible Plan. As a COBRA Member, the Member may elect the \$ \$1,800 Deductible Plan.)

The length of the continuation period will depend on the qualifying event. If an Employee or eligible Spouse and Dependent is determined by Social Security to have been disabled prior to or within 60 days following the date of the qualifying event, he or she may obtain an extension of the COBRA continuation period from 18 months to 29 months (with proof of disability). Anyone electing continuation coverage may be charged 102% of the group rate charged for the same coverage.

If Medicare or another health plan is in effect prior to the COBRA effective date, the Employee and/or Spouse and Dependent must be offered COBRA and may elect to participate in COBRA coverage as well as Medicare or another health plan, with COBRA as the secondary payer.

CONTINUATION COVERAGE ENDS

Continuation of coverage may be terminated or denied on the earliest date which may apply for any of the following reasons:

- (a) The Employee (while not actively employed) or covered Spouse and Dependent acquires coverage under another group health, dental, or vision plan or any other plan (Medicaid, TriCare or other Federal programs);
- (b) The contribution for continuation coverage is not paid on time, including a grace period of 30 days after a payment due date or a period of 45 days following the day the qualified beneficiary initially elected continuation coverage;
- (c) The Employee (while not actively employed) or covered Spouse or Dependent is entitled to or enrolled in Medicare or Medicaid after COBRA continuation coverage begins;
- (d) The State of South Dakota no longer provides group Health Coverage; or
- (e) The continuation period ends.

HEALTHCARE CERTIFICATIONS

If an Employee, Spouse or Dependent loses coverage under the Plan, the Plan Administrator will provide a Certificate of Prior Health Coverage. The purpose of the Certificate is to enable the Employee, Spouse or Dependent to provide proof of prior health plan coverage to a subsequent health plan. Certificates will be provided automatically when the coverage ends under the Plan and when the COBRA coverage (if any) ends.

CONVERSION OF COVERAGE

The Plan does not offer the opportunity to convert Health Coverage to an individual policy when COBRA continuation coverage ends.

VERIFICATION OF TOBACCO USER STATUS

IDENTIFICATION OF TOBACCO USER STATUS

As part of the enrollment process, new Employees must indicate whether they and/or their covered Spouse use tobacco. Employee and Spouse contributions for Health Coverage during the Plan Year will be based on the Employee's response to the tobacco use question.

This election is required even if the Employee is not making any other benefit choices.

CHANGES TO TOBACCO USER

If an Employee and/or the covered Spouse change from being non-tobacco users to tobacco users during the Plan Year, the Employee must complete a "Tobacco Use Election Form" (available at <http://benefits.sd.gov> or by calling the Bureau of Human Resources) to indicate the change in tobacco use.

If a Spouse is added to the Health Plan during the Plan Year, the Employee must provide all required information about the Spouse's tobacco user status. (See the chart on next page for details about the effect of the tobacco user contribution rate.)

CHANGES TO NON-TOBACCO USER

If an Employee and/or the covered Spouse change from being a tobacco user to a non-tobacco user during the Plan Year, one of the following is required:

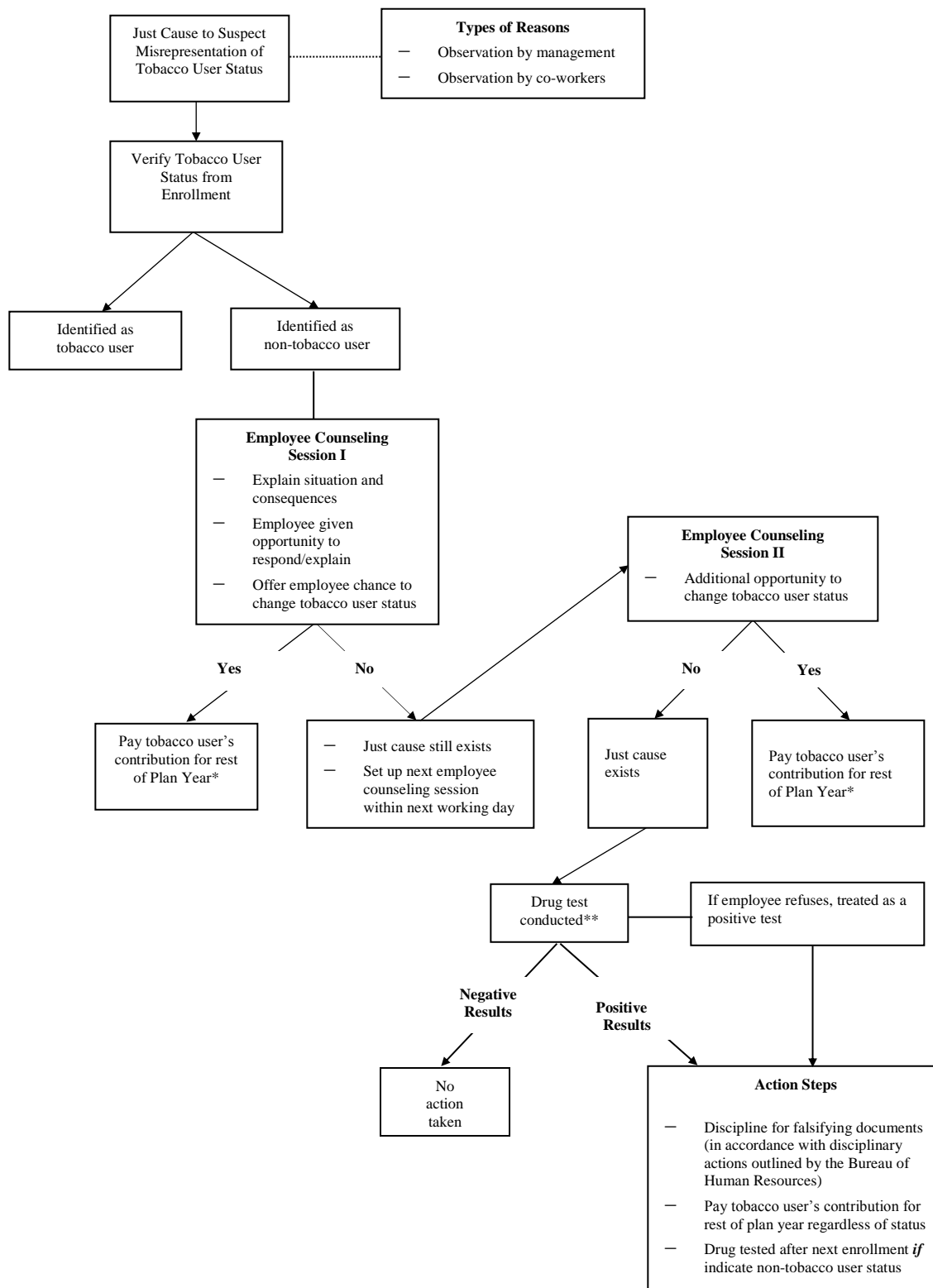
- 1) The Employee must change the tobacco user election by logging on to the Internet Enrollment System during Annual Enrollment,
- 2) Employee or Spouse successfully complete the South Dakota Department of Health tobacco QuitLine (866.SDQUITS or 866.737.8487) and submit a copy of the QuitLine certificate of completion to the Bureau of Human Resources, or
- 3) Employee submits written documentation to the Bureau of Human Resources stating the employee or Spouse has been tobacco-free for a minimum of 120 days.

VERIFICATION OF TOBACCO USER STATUS

The State reserves the right to verify an Employee's tobacco user status during the Plan Year, and the Employee could face disciplinary action and/or the reduction of health and life benefits if tobacco use is misrepresented.

The following flowchart shows the process when, if reasonable or just cause indicates an Employee has misrepresented tobacco use. Just or reasonable cause may include, but is not limited to, reported observations of tobacco use by a co-worker or management staff.

The following non-tobacco incentive policies are in line with the overall movement by the State toward wellness, prevention, and managed care. According to the Centers for Disease Control and Prevention, cigarette smoking is the leading preventable cause of death in the United States. Employees and covered Spouses using tobacco are encouraged to contact the Department of Health's SD Quitline at 866.737.8487 or <http://sdquitline.com/> for more information.



* Employee may re-enroll the following Plan year as a non-tobacco user, without proof of tobacco user status.

** The drug test to determine if an Employee is currently using tobacco will be administered through a certified testing laboratory. The cost of administering the test will be paid by the State.

CLAIMS PAYMENT PROCESS

A claim for benefits must be made to the Plan Administrator in writing within one year after the end of the Plan Year in which the charges are Incurred. A written claim must include the following information:

- (a) Date of service;
- (b) Insurance coding (procedure CPT code, diagnosis code);
- (c) Provider tax ID number;
- (d) Policy holder information;
- (e) Patient name, ID number, and date of birth; and
- (f) Cost of the procedure(s) or service(s) performed.

A claim must be decided within a reasonable period of time, but not later than 30 days after the Plan has received the claim. If, because of reasons beyond the Plan's control, more time is needed to review the claim, the Plan may extend the time period up to an additional 15 days.

Failure to furnish proof of the service received within the time limit may not result in denial or reduction of a claim if it is shown:

- (a) It was not reasonably possible to provide the proof within the time limit that applies; and
- (b) Proof was provided as soon as reasonably possible.

Approval for processing must be obtained from the Bureau of Human Resources. Upon completion, Members should receive an Explanation of Benefits (EOB).

Members are encouraged to examine Hospital and doctor bills for accuracy to ensure services are received for charged amounts. Member should also review any Explanation of Benefits (EOB) received from DAKOTACARE for possible processing errors.

BENEFIT PAYMENTS

Upon receipt by the Plan Administrator of a claim, benefits under the Plan are paid as follows:

- (a) The Plan Administrator may elect to pay the benefits directly to the Hospital or other provider. The Plan Administrator reserves the right to refuse assignment of benefits to any provider.
- (b) Benefits to which the Employee is entitled which remain unpaid at the Employee's death are paid to the Employee's beneficiary, if a designated beneficiary (Spouse and/or other designated Dependent) survives the Employee. Otherwise, the benefits are paid to the Employee's estate.
- (c) The Plan Administrator has complete discretion to interpret the provisions of the Plan, make findings of fact and assign benefit payments. Decisions by the Plan Administrator will be final and binding on Plan Members, subject to a grievance on the Employee's part to challenge denials. See "Appealing a Denied Claim" for information about the grievance procedure.

PHYSICAL EXAMS, AUTOPSY, SECOND OPINIONS, AND RELEASE OF INFORMATION

The Plan Administrator, at its own expense, may require the person whose Injury, disease, or condition is the basis of a claim be examined by a Physician chosen by it. The Plan Administrator may require an exam as often as is reasonable while a claim is pending. In case of death, it may require an autopsy where the law does not forbid it to do so.

The South Dakota State Employee Health Plan covers Physician consultation services when Incurred as a result of voluntary second surgical opinions or other requirements of the Managed Care Program. Voluntary second opinions are subject to the same Deductible, Copayments, and Coinsurance provisions that apply for any other surgical or medical procedures under the Plan. The Plan Administrator may require second opinions for certain covered services and for surgical procedures that must be redone because the Patient did not follow Physician instructions. See “Services Requiring Second Opinions”.

The Employee is responsible for providing the Plan Administrator or the Claims Administrator with the information needed to administer the Plan and to process and pay claims. For example, to Opt-Out of coverage under this Plan, the Employee must provide a signed letter from the other group health plan stating that he or she has coverage elsewhere. To ensure proper coordination of benefits, the Employee must provide an Explanation of Benefits for any benefits paid by another group health plan. In addition, by enrolling and participating in the Plan, the Employee agrees to cooperate in claims audits and agrees that the Plan Administrator has the right to contact any other organization or person whenever necessary to obtain additional information about a claim.

CLAIMS ADMINISTRATOR’S RIGHT TO INVESTIGATE CLAIMS

By submitting a claim for benefits or reimbursement, the covered Member is certifying the information on the claim form is true and complete to the best of his or her knowledge and belief.

The covered Member is also agreeing that the Plan Administrator and/or Claims Administrator have the right to investigate the claim, if necessary, or to contact any other organization or persons to obtain additional information about the claim. This investigation may be conducted prospectively or retrospectively.

The claim will be denied if the covered Member misrepresents, falsifies, or omits information necessary to process the claim.

BILLING AND PROCESSING ERROR INCENTIVE PROGRAM

Members are encouraged to examine Hospital and doctor bills for accuracy to ensure services are received for charged amounts. Member should also review any EOB received from DAKOTACARE for possible processing errors.

If an error is found on a bill or EOB, the Plan will pay the Member 50% of the money saved by the Plan. The minimum savings to the Plan to qualify for a payment is \$50. The maximum payment is \$1,000 per medical occurrence.

When reviewing Hospital or doctor bills, keep in mind that this incentive applies only to covered charges for inpatient Hospital care, outpatient surgery in an ambulatory care facility, or services received from clinics and related tests. It applies to any processing errors found on an EOB.

Member is responsible for:

- Auditing charges and EOB payments;
- Requesting corrected billings from providers or corrected EOB from DAKOTACARE; and
- Submitting all documentation to the Bureau of Human Resources for processing.

Documentation required for Bureau of Human Resources:

- Copy of the incorrect bill or EOB;
- Corrected bill or EOB; and
- Brief explanation of the error.

NOTE: With Diagnostic Related Group (DRG) and Tier 1 based billing, itemized charges do not affect the Hospital bill. The billing error incentive does not apply to these Hospital bills.

CLAIMS ACTION

To receive benefits, the Member or the provider must file a claim for services. Participating DAKOTACARE and Sanford providers will file claims on behalf of the Patient.

Benefits will not be paid until the Member has sufficient medical expenses to satisfy the Plan Year Deductible, unless preventive or conditions management benefits are applicable. Claims must be filed within one year after the end of the Plan Year in which expenses are Incurred. If the Member's claim is late, it will not be denied or reduced if the Member can show that the claim was submitted within a reasonable time.

The Member may request benefits be paid directly to him or her. However, the State, as the Employer, reserves the right to assign benefit payments to a healthcare provider or to the Member or a covered Spouse or Dependent. Formal cost containment agreements with providers may preclude sending benefit payments directly to Members or covered Spouse or Dependent.

After filing a claim, the Member will receive an EOB statement from the Claims Administrator processing the claim. The EOB will explain in detail the amount of benefit received for each item in the claim.

APPEALING A DENIED CLAIM OR ADVERSE DETERMINATION

The Member will be notified in writing if a claim for benefits is denied. The EOB will include the specific reason(s) the claim was denied.

If a claim is denied, the Member may appeal to the Director of Employee Benefits, c/o the Bureau of Human Resources, within 30 days of receiving notification of the adverse determination. The Member will receive a decision within 30 days from the date the complaint is received. If the Director upholds the adverse determination, the Member will be notified of their right to an external review. The member has four months after receipt of the Director's notice of an adverse determination to request an external review.

An external review is requested by filing a request with an independent review organization through the Department of Labor and Regulation, Division of Insurance, within four months after receipt of notice of an adverse determination. The forms for external review can be found at <http://benefits.sd.gov/Forms.aspx>. The external review process can take up to 45 days from the date the member's request for external review is received by the Department of Labor and Regulation, Division of Insurance.

An expedited external review is available only if the member's treating health care provider certifies the time frame for the standard external review would seriously jeopardize the life or health of the covered member or would jeopardize the covered member's ability to regain maximum function.

An experimental review is available if the member:

- has a terminal medical condition, life threatening condition, or a seriously debilitating condition;
- standard treatments have not been effective, not medically appropriate, or there are no standard treatments;
- the member's provider recommends the treatment that has been denied and considers it likely to be beneficial;
- the treatment will be significantly less effective if not promptly initiated; and

- the provider's medical opinion is based on valid studies and the denied treatment is likely to be more beneficial to the member than available standard treatments.

Both the expedited and experimental reviews must have a form from the member's treating health care provider submitted with the standard external review form.

An independent review organization's external review decision is binding on the South Dakota State Employee Health Plan except to the extent the South Dakota State Employee Health Plan has other remedies available under applicable state law. An independent review organization's external review decision is binding on the member except to the extent the eligible employee or any other person has other remedies available under applicable federal or state law.

If the adverse determination is upheld by the independent review organization, the Member may appeal the decision to the circuit court in accordance with SDCL 1-26.

LEGAL ACTION

No legal action or suit to recover on the Plan may be started before 60 days after written proof of loss has been furnished. Further, no legal action or suit may be brought more than 3 years after the time proof of loss must be furnished. But, if either time limit is less than permitted by state law where the Member resides when the loss occurs, that limit is extended to agree with the shortest limit the law of that state allows.

SUBROGATION AND REIMBURSEMENT

When a Member becomes ill or injured because of the actions or inactions of a third party, the Plan may cover eligible health care (medical, dental, and vision) expenses, regardless whether the Plan includes or excludes coverage for the cost of claims arising from care or treatment. However, to receive coverage, the Member must notify the Plan the illness or Injury was caused by a third party, and the Member must follow special Plan rules. When this happens, the Plan is subrogated and has a right of reimbursement as described herein, unless otherwise prohibited by law. This section describes the procedures with respect to subrogation, reimbursement, and right of recovery.

"Reimbursement" means that if a third party is obligated to pay for the costs arising from or connected to an illness or Injury, the Plan is permitted to recover from the third party or the Member any amount of money paid by the third party or to the Member in connection with the illness or Injury. For example, if the Member receives insurance proceeds or monetary damages on account of illness or Injury arising from an accident caused by a third party or insured by a third party, the Plan will be able to seek reimbursement from the third party or the Member to recover the costs paid by the Plan.

The Plan will have a first priority lien on all sums paid by a third party or received by the Member equal to the sums paid by the Plan to cover the care arising from the illness or Injury caused by a third party or for which a third party insurance company was required to pay money to the Member. The Plan's first priority lien will not be subject to, or set-off by any attorneys' fees or expenses the Member or any insurance company is required to incur in order to recover damages for the illness or Injury for which the Plan paid benefit claims on a Member's behalf.

"Subrogation" means that if an illness or Injury is the fault of someone else, the Plan has the right to seek expenses it pays for that illness or Injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to the Member by the at-fault party or any other party related to the

illness or Injury. The Plan's subrogation right is not subject to any attorneys' fees or expenses that the Member or any insurance company may incur to recover damages for illness or Injury for which the Plan paid claims on a Member's behalf.

Therefore, by accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or Injury, the member agrees that the Plan:

- Has a first priority lien on any and all monies paid (or payable) to member or for the member's benefit by any responsible party or other recovery to the extent the Plan paid benefits for such illness or Injury;
- May appoint the member as constructive trustee for any and all monies paid (or payable to) the member or for the member's benefit by any responsible party or other recovery to the extent the Plan paid benefits for such illness or Injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the illness or Injury.

If the member (or the member's attorney or other representative) receives any payment, however characterized, from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or Injury is a result of a third party, the member agrees to place the funds (without reduction for attorneys' fees or otherwise) in a separate, identifiable account and that the plan has a, first priority lien on the funds, and the member agrees to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or Injury. This means the member will be deemed to be in control of the funds.

As a consequence the member must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or Injury for the member. The member must pay the Plan back up to the full amount of the compensation the member receives from the responsible party, regardless of whether the settlement or judgment says that the money received (all or part of it) is for health care expenses. Furthermore, the member must pay the Plan back regardless of whether the third party admits liability and regardless of whether the member has been made whole or fully compensated for the illness or Injury. If any money is left over, the member may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorneys' fees and costs) the member incurs in obtaining the funds. The Plan's sources of payment through subrogation or recovery include, but are not limited to the following:

- Money from a third party that the member, the member's guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that the member, the member's guardian or other representatives receive;
- Any lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to the member, the member's guardian, or other representatives.

Each Member is required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary;
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of the member's intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained illness or injuries; and
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate the member's Plan participation, offset future benefits or use other measures in the event that the member fails to provide the information, authorizations, pay to the Plan the monetary value of all claims made, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of third party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of third party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

The Plan also reserves the right to pursue recovery from the third party at its discretion should the Member decide not to attempt recovery. The Member must notify the Bureau of Human Resources, Benefits Program, or the Claims Administrator immediately about any illness or Injury that may have been caused by a liable third party.

COORDINATION OF BENEFITS (COB)

BENEFITS SUBJECT TO THIS PROVISION

All benefits under medical coverage in the Plan are subject to this provision.

There is no Coordination of Benefits between the Prescription Drug Plan and any other medical or prescription drug plan, previously or currently in place with a Plan Member.

End-stage renal disease pharmaceuticals prescribed for Medicare recipients (not including age 65+ retirees) will be coordinated with the South Dakota State Employee Health Plan. Claims for these pharmaceuticals should be submitted to DAKOTACARE using the Plan Claim Form.

If other valid and collectible insurance is available to an “insured” for a loss, covered by this Plan, it shall be primary, and the coverage under the South Dakota State Employee Health Plan shall be excess over any other insurance.

DEFINITIONS

As used in this provision:

- (a) **“Allowable Expense”** - Limited to those expenses that would be incurred by the Member through same or similar treatment at a provider or facility where the State has a direct contract for specific treatment.
- (b) **“Claim Period”** - A Plan Year. If a person is not covered under the South Dakota State Employee Health Plan for a full Plan year, the Claim Period for that year will be the part of the year during which the person was covered under the Plan.
- (c) **“Medical Coverage”** - Any coverage in the Plan providing benefits for any type of charge for which Medicare provides benefits.
- (d) **“Plan”** - A plan, insured or not, which provides benefits or services for medical, dental, or vision care through:
 - 1) Group, individual or blanket coverage;
 - 2) Group practice or other group prepayment coverage, including Hospital or medical services coverage;
 - 3) Labor-management trusted plans;
 - 4) Union welfare plans;

- 5) Plan Administrator organization Plans;
- 6) Employee benefit organization Plans; or
- 7) Coverage required or provided by law or government programs, except Medicaid. However, this coverage will not be considered a Plan, if covered expenses under the coverage are excluded from benefits under the South Dakota State Employee Health Plan.

The parts of a Plan, which coordinate benefits or services with other Plans, and the parts that do not coordinate benefits are considered separate Plans. For purposes of this Section, the term “Plan” refers only to those parts of a Plan, which provide benefits that are subject to this provision.

- (e) **“Primary to Medicare”** - Medicare is not considered for the purpose of the Coordination of Benefits provision for active Employee. When a medical coverage is primary to Medicare, the benefits under that coverage are not coordinated with the ones that Medicare provides.
- (f) **“Senior Dependent”** - The Spouse of an active Employee while:
 - 1) The Spouse is age 65 or over and qualifies as a Dependent of the Employee; and
 - 2) The Employee’s Dependents are eligible under the Plan.
- (g) **“Senior Employee”** - Any active Employee age 65 or over who belongs to a class of employees eligible for medical coverage.

EFFECT ON BENEFITS

- (a) Coordination of Benefits apply to Allowable Expenses Incurred during any Claim Period by a covered Employee, Spouse or Dependent, if the sum of the benefits payable for those Expenses listed below would exceed the Allowable Expense:
 - 1) This Plan in the absence of this provision; and
 - 2) All other Plans in the absence of similar provisions.
- (b) If Coordination of Benefits applies to a Claim Period, this Plan will reduce the benefits it would have otherwise paid for Allowable Expenses Incurred by the claimant during the Claim Period.

The reduction will be made to the extent needed. The sum of the reduced benefits and the benefits payable for Expenses under all other Plans coordinating benefits does not exceed the Allowable Expenses.

Benefits payable under another Plan include:

- 1) Those which would have been payable had a claim been duly made; and
- 2) In the case of Medicare coverage, all benefits, including Optional Benefits, whether or not the claimant is enrolled in these.

- (c) To determine benefits, this Plan will ignore another Plan if:
- 1) The other Plan which is coordinating its benefits with those of this Plan has a rule stating that it will determine its benefits after the benefits of this Plan have been determined; and
 - 2) The rules set forth in (d) below would require this Plan to determine its benefits before such other Plan.
- (d) For the purpose of (c) above, here is the order in which this Plan determines benefits.
- 1) The benefits of the Plan which covers the person as an Employee, Member, subscriber or COBRA subscriber (that is, other than as a Spouse or Dependent) are determined before those of the Plan which covers the person as a Spouse or Dependent.
 - 2) Except as stated in (3) below, when this Plan and another Plan both cover a Dependent child whose parents are separated or divorced:
 - (A) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; however
 - (B) If both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.

If the other Plan has a rule based upon the gender of the parent instead of the rules described in (A) or (B) and if, as a result, the Plans do not agree on the order of benefits, the rules in the other Plan will determine the order of benefits.
 - 3) If 2 or more Plans cover a person as a Dependent Child of divorced or separated parents, benefits for the child are determined in this order:
 - (A) First, the Plan of the parent with custody of the child;
 - (B) Second, if the parent with custody has remarried, the Plan of the Spouse of the parent with custody of the child; and
 - (C) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Period or Plan Year during which any benefits are actually paid or provided before the entity has actual knowledge.

- 4) The benefits of the Plan which cover a person as an Employee who is actively at work (or a Spouse or Dependent of such person) are determined before those of a Plan which cover the person as a laid off or Retired Employee (or a Spouse or Dependent of such person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, the rules in the other Plan will determine the order of benefits.
 - 5) If none of the above rules determines the order of benefits, the benefits of the Plan, which covered an Employee, Member, or subscriber longer, are determined before those of the Plan, which covered the person for the shorter time.
- (e) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefits limit of this Plan.

MEDICAL COVERAGE FOR SENIOR EMPLOYEES

A person is deemed to be age 65 or over from the first day of the month in which the person attains age 65.

NOTE: Employees are not allowed to Opt-Out of the South Dakota State Employee Health Plan solely on the basis of Medicare and Medicaid eligibility. These programs are not considered valid group coverage for purposes of this provision.

A Senior Employee is eligible for the same medical coverage as younger Employees in the class to which the Senior Employee belongs.

Whether hired before or after age 65, Employees who enroll in the South Dakota State Employee Health Plan within 30 days of date of hire are covered for medical coverage one month and one day from date of hire. A Continuing Employee will have coverage begin on the first day of the month following the month in which they were rehired.

While the Senior Employee remains covered for medical coverage, the Senior Employee's benefits under the coverage will be primary to Medicare so long as the Senior Employee is actively employed. However, the Senior Employee will not remain covered for any medical coverage after the earlier of the date the Senior Employee's benefits under that coverage would end if the Senior Employee was under age 65; or if the Employee terminates employment, the end of the period covered by the Senior Employee's last contribution for the coverage.

The ending date of Health Coverage will be based on the pay period for which the Employee received his or her final paycheck. Employees should contact their Human Resource Office for specific information.

MEDICAL COVERAGE FOR A SENIOR SPOUSE

An Employee's Senior Spouse is eligible for the same medical coverage as younger Spouses of Employees in the class to which the Employee belongs.

While the Employee's Spouse (remains covered for medical coverage, the Employee Spouse's (benefits under the coverage will be primary to Medicare.

Medical coverage for the Employee's Spouse will end as indicated below:

- (a) As the Spouse of an Active Employee, medical coverage will end on the date the Employee terminates employment or benefits under that coverage would otherwise end.

- (b) As the Spouse of a retiree, medical coverage under this Plan will end the first of the month in which the Spouse turns age 65.

MEDICAL COVERAGE FOR RETIRED EMPLOYEES

Medicare is primary to the South Dakota State Employee Health Plan for Members and Spouses who are retired. Medical coverage under the South Dakota State Employee Health Plan will end the first of the month in which the Member turns age 65. At that time, coverage may be converted to the State-sponsored Medicare Supplement Plan.

MEDICAL COVERAGE FOR CERTAIN EMPLOYEES, SPOUSES, AND DEPENDENTS

Whether this Plan is the primary payer of medical and pharmaceutical claims for an Employee or covered Spouse or Dependent with end-stage renal disease depends on which occurs first: End-stage renal disease or attainment of age 65.

This Plan has secondary responsibility for the claims of a covered Member:

- (a) Who is eligible for Medicare benefits because of end-stage renal disease; but
- (b) Who first became eligible for Medicare Part A because of age or another disability.

This Plan has primary responsibility for the claims of a Member who is eligible for Medicare benefits solely because of end-stage renal disease, and then later also becomes eligible for Medicare benefits because of age or another disability.

PLAN ADMINISTRATION AND OPERATIONS

The South Dakota State Employee Health Plan is a “self-funded” Plan. The benefits under the Plan are neither vested, nor non-forfeitable. The Bureau of Human Resources is the State agency responsible for designing and administering the Plan, including the administration and payment of claims. The Plan Administrator reserves the right to change the Plan design, modify coverage, and change contributions or funding mechanisms at any time it deems necessary, with or without notice. The Plan Administrator or other fiduciary designated by the Plan Sponsor shall have final authority to make a determination with respect to such issues or such provisions, unless such determination is found to be arbitrary and capricious by a court of appropriate jurisdiction. The information contained in this document and its interpretation by the Plan Administrator’s designee supersedes all verbal representations of the Plan provisions. The benefits paid are funded entirely by the contributions paid by the State and participating Employees.

The State of South Dakota pays the contribution for coverage for an Active Employee under the \$750 Deductible Plan or the \$1,800 Deductible Plan.

The Employee pays the contribution for Spouse and Dependent coverage under the Plan.

The amount of such contribution will be established by the Bureau of Human Resources, at its sole discretion.

RIGHT TO RELEASE AND OBTAIN NECESSARY INFORMATION

The Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other person or organization any information, which it deems needed to:

- (a) Determine if a Plan provision applies; and
- (b) Implement its terms or the terms of any provision of similar purpose of any other Plan.

Any claimant under this Plan shall furnish to the Plan Administrator the necessary information as may be needed to implement this provision.

FACILITY OF PAYMENT

If the payments, which should have been made by this Plan under the terms of this provision, are made under other Plans, the Plan Administrator may, at its discretion, pay to any person making such payment the amount it determines satisfies the intent of this provision. To the extent of the amount of those payments, the Plan Administrator shall be discharged from liability under this Plan.

RIGHT TO RECOVERY

If the Plan Administrator makes payments with respect to Allowable Expenses in a total amount, which is, at any time, in excess of the payment necessary at the time to satisfy the intent of this provision, it will have the right to recover such excess from:

- (a) Any persons to or for or with respect to whom such payments were made; and
- (b) Any organization, which should have made the payments.

ASSIGNMENT

The Plan Administrator retains the right to assign or to refuse assignment of benefits to providers.

PLAN MODIFICATION AND AMENDMENT

The State of South Dakota fully intends to continue the Plan or a similar Plan indefinitely. However, the Plan may be modified and amended at any time by the State of South Dakota or the Bureau of Human Resources upon its due approval of such modification or amendment. The modification or amendment shall be effective on the date of approval or on such date as the State of South Dakota may determine in connection therewith. Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan.

SEVERABILITY

If any portion of this Plan is subsequently found to be invalid by a court of law, the remaining provisions of the Plan will remain in effect.

PLAN TERMINATION

The State of South Dakota or the Bureau of Human Resources may terminate the Plan at any time as of the date it authorizes. In the event of such termination, the State of South Dakota shall have no obligation under the Plan beyond paying the difference between:

- (a) The claims Incurred (even though later filed) and expenses of the Plan due up to the date of termination plus extended benefits, if any, provided under the Plan; and
- (b) The funds available to pay such claims, expenses, and extended benefits.

Such claims and expenses shall be paid from the funds in the Plan. No benefits will be paid for expenses Incurred after the date the Plan ends.

The Bureau of Human Resources has the final and binding authority to determine claims and direct the payment thereof. The Bureau of Human Resources shall incur no liability for failure to make payment of any claim or to make ratable distribution on any claim without regard to the reasons therefore. The Bureau of Human Resources shall have the right to employ third party administrators (TPA) under the Plan to aid it in the discharge of its duties hereunder.